Title V Block Grant

FY 04 Application

&

FY 02 Annual Report

Texas Department of Health

Associateship for Family Health

Community Health and Resources Division

July 2003

Notes for the readers of this document:

Online Application

In 2003, the Health Resources and Services Administration, Maternal and Child Health Branch, required all applicants to submit their Title V Block Grant Application using an on-line web-based format. In order to meet the informational needs of our stakeholders and other interested readers, and due to the complexity of the on-line system, Texas Title V staff translated the online contents into a Word based document. Minor additions to text (*noted in italics*) represent changes added to aid in understanding and readability.

Updates to Block Grant Application

The grant application guidance includes instruction for including additional text in continuation years. The FY 2004 application is for continuation funding and includes text from previous applications as well as new text added in the FY 2004 application. New text is noted in the attached by a /2004/ at the beginning of the new text followed by a **//2004//** at the end of the new text (i.e. /2004/ new text //2004//).

TDH

Eduardo J. Sanchez, M.D., M.P.H.
Commissioner of Health

1100 West 49th Street
Austin, Texas 78756-3199

http://www.tdh.state.tx.us
1-888-963-7111

Ben Delgado
Chief Operating Officer

Nick Curry, M.D., M.P.H..
Executive Deputy Commissioner

Ms. Cassie Lauver:
Title V Block Grant
HRSA Grants Application Center
901 Russell Avenue
Suite 450
Gaithersburg, MD 20879

July 13, 2003

Dear Ms. Lauver:

As Associate Commissioner for Family Health of the Texas Department of Health (TDH), I hereby submit this letter to apply for the Maternal and Child Health Services Block Grant funds for federal fiscal year 2004. Our online application has been completed in accordance with this year's grant guidance.

Due to online application space limitations, Texas summarized the many working reports prepared for this grant application in order to meet those limits. The detailed working documents will be retained by the State Title V Director and will be available at the Block Grant Application review scheduled for August 15, 2003 in Dallas.

Should you have questions or need additional information, please contact Dr. Fouad Berrahou at 512-458-7312.

Thank you for your consideration and review of Texas' submitted application for FY 2004.

Sincerely,

Debra Wanser

Debra Wanser, R.N. M.P. Aff
Associate Commissioner
Associateship for Family Health

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-0043

2. DATE SUBMITTED	Applicant Identifier
July 15, 2003	433-AP-1
3. DATE RECEIVED BY STATE	State Application Identifier: N/A
4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

1. TYPE OF SUBMISSION:

Application	Preapplication
☐ Construction	☐ Construction
☑ Non-Construction	☐ Non-Construction

5. APPLICANT INFORMATION

Legal Name:	Organizational Unit:
Texas Department of Health	Associateship for Family Health
Address *(give city, county, State, and zip code)*: 1100 West 49th Street, Austin, Texas 78756	Name and telephone number of person to be contacted on matters involving this application *(give area code)*: Debra Wanser, R.N., M.P. Aff., Assoc. Comm. 512-458-7321

6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 74-6000182

7. TYPE OF APPLICANT: *(enter appropriate letter in box)* A

A. State; B. County; C. Municipal; D. Township; E. Interstate; F. Intermunicipal; G. Special District; H. Independent School Dist.; I. State Controlled Institution of Higher Learning; J. Private University; K. Indian Tribe; L. Individual; M. Profit Organization; N. Other (Specify) _____

8. TYPE OF APPLICATION:

☐ New ☑ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) ☐ ☐

A. Increase Award B. Decrease Award C. Increase Duration
D. Decrease Duration Other*(specify)*: _____

9. NAME OF FEDERAL AGENCY:

Health Resources & Services Administration-MCHB

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 93-994

TITLE: Maternal and Child Health Servies Block Grant

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

Maternal and Child Health Services Block Grant

12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*:

Statewide - Texas

13. PROPOSED PROJECT

Start Date	Ending Date
10/1/03	9/30/04

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant	b. Project
10	Statewide - Texas

15. ESTIMATED FUNDING:

a. Federal	$ 40,617,420.00
b. Applicant	$ 4,814,560.00
c. State	$ 43,821,011.00
d. Local	$ .00
e. Other	$ 567,000.00
f. Program Income	$ 2,240,648.00
g. TOTAL	$ 92,060,639.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE _____

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes," attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Type Name of Authorized Representative	b. Title	c. Telephone Number
Debra Wanser, R.N., M.P. Aff	Associate Commissioner	(512) 458-7321

d. Signature of Authorized Representative: Debra Wanser

e. Date Signed: 7/15/03

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Standard Form 424 (Rev. 7-97)
Prescribed by OMB Circular A-102

TABLE OF CONTENTS

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

The Letter of Transmittal is the page one (1) of this document and precedes this section.

B. FACE SHEET

The face sheet is the SF424, Application for Federal Assistance. This form must be completed offline and mailed to:

Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishes Lane, Room 18-31
Rockville, MD 20857

The Face Sheet (SF 424) is page two (2) of this document and precedes this section.

C. ASSURANCES & CERTIFICATIONS

As per the Title V Block Grant Guidance dated May 31, 2003 the appropriate assurances and certifications are being maintained in the Title V Director's office and are available upon request. Please call Fouad Berrahou and/or Maria Vega at 512-458-7111 if you have questions or need to view the assurances and certifications.

D. TABLE OF CONTENTS

You do not need to add the Table of Contents. The Table of Contents is provided for you as shown in the guidance.

The Table of Contents is page 3 of this document and precedes this section.

E. PUBLIC INPUT

Since the planning and implementation phases of the Title V budget realignment projects for FY 02 and FY 03 and the recent reductions in Title V state appropriations as a result of the recently completed 78th Texas Legislative Session, Title V has been working very closely with its stakeholders (i.e.,

consumers, local health departments, Title V-funded providers). The dialogue between the Title V program and its stakeholders has been around the need to realign the Title V program budget with annual appropriated funding levels and to define the role of public health in MCH direct, enabling, and population-based/infrastructure building services as the health care environment continues to change; particularly in light of new legislative laws affecting Title V population effective September 1, 2003. Some the information collected has been used in this application submission, while the remaining information - which provides an overwhelming amount of input - will be addressed in the next 5-year needs assessments.

The FY 04 Application also will be made available to facilitate comment after its transmittal. It will be posted on the Title V web site. Copies will be sent to the Texas State Library, the Governor's Office and the Legislative Budget Board, and will be made available for TDH Advisory Committee members. A notice will be sent to all persons on the Title V interested persons mailing list to provide the opportunity to download the application or to request a hard copy.

II. NEEDS ASSESSMENT

In application year 2004, the Needs Assessment may be provided as an attachment to this section.

See Appendix A for the needs assessment update for FY 2004.

III. STATE OVERVIEW

A. OVERVIEW

The purpose of the Texas Title V Program is to address the overall intent of the Maternal and Child Health (MCH) Services Block Grant to improve the health of all women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The State of Texas has responsibility to: provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations.

Texas' Title V Program operates within the strategic plan framework articulated by Texas State Government, the Texas Health and Human Services Commission (HHSC) and the Texas Department of Health (TDH) and is an important component in achieving the Visions, Missions, Philosophies, and Benchmarks for Texas' priority goal for health and human services as outlined by the Governor's Office of Budget and Planning is to reduce dependence on public assistance through an efficient and effective system that promotes the health, responsibility, and self-sufficiency of individuals and families. The statewide benchmarks

relevant to this goal are consistent with requirements of Title V and Title V national outcome and performance measures. The relevant statewide benchmarks include:

- infant mortality rate;
- low birth weight rate;
- teen pregnancy rate;
- percent of births that are out-of-wedlock;
- incidence of vaccine-preventable disease; and
- number of surveillance activities and field investigations conducted for communicable disease injury or harmful exposure.

The Vision, Mission and Philosophy of the TDH further support and strengthen the Texas Title V Program.

TDH Vision Statement: Texas is healthy people and healthy communities.

TDH Mission Statement: We partner with the people and communities of Texas to protect, promote and improve health. We accomplish our mission by providing and supporting the essential public health services of:

- Surveillance, diagnosis and investigation of diseases, health problems and threats to the public's health.
- Education, empowerment and mobilization of individuals and communities to prevent health problems and improve their health status.
- Promotion of health policies and planning for individuals and community efforts to improve their health.
- Regulation and enforcement of public health laws and policies necessary to control disease and protect the public's well being.
- Facilitating access to health services for individuals of greatest need.
- Critically evaluating and refining our public health activities and workforce competence.
- Supporting the health care safety net for: children and adults with special health care needs, uninsured and underinsured people and families.

TDH Philosophy Statement: We will accomplish our mission and goals by adhering to these values:

- Integrity in all of our actions to build public trust.
- Inclusiveness and diversity of perspectives to achieve the best solutions.

- Partnerships with people, communities and organizations to build a successful public health system.
- Accountability and responsibility to guide our use of public resources.

At the core of TDH's strategic plan are newly articulated priority needs created in partnership with internal and external stakeholders and consumers, the Board of Health and TDH executive managers. These priority needs have informed TDH of the need to strengthen the health status of individuals and to enhance public health systems in Texas. During the strategic planning cycle, TDH has set five priorities to achieve a healthy Texas that are consistent with Title V. Three priorities focus on improving the health of Texans:

- Protect Texans against vaccine-preventable diseases by improving immunizations rates;
- Focus on fitness by promoting healthy eating and regular physical activity; and
- Eliminate disparities in health among population groups in Texas.

Two priorities focus on strengthening the public health system to better address health challenges:

- Improve our ability to respond to disasters or disease outbreaks whether they are intentionally caused our naturally-occurring; and
- Improve the efficiency and effectiveness of TDH business practices.

All five priorities are discussed in detail in the Needs Assessment Section of the FY 03 application.

The success of the State's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following demographic, economic, and social trends provide an overview of some of these important characteristics for Texas.

/2004/ These priorities remain primary focuses of the department. They are a focus of much of the rest of this overview and will also be explored and addressed in the next five-year needs assessment. //2004//

/2004/ TDH Public Health Region Structure:

Texas is organized into 11 public health regions. Staff in regions includes leadership, administrative structures and programmatic representation at the regional level who not only provides population based and enabling services but also in some cases (e.g., dental, immunizations, family planning and prenatal care) direct care services where a local health department is not present. The

attached map (see Appendix B) will provide a reference point for further reading on efforts in the regions. **//2004//**

Demographic Trends.

/2004/ According to the State Data Center and Demographer, by the year 05 Texas' population is expected to grow from the current 20.8 million to 22.4 million and projected to be 35.0 million in 2040. The area with the highest level of population growth includes the Texas-Mexico border, Texas' central corridor from Dallas-Fort Worth through San Antonio and the Houston-Galveston area. Slower rates of growth are seen in the Panhandle, West Texas and Beaumont-Port Arthur areas. It is interesting to note, given Texas' vast geographical area, that by 2000 nonmetropolitan counties accounted for only 15.2% of Texas' total population (and accounted for only 8.8% of Texas' 1990s population increase), while metropolitan counties accounted for 84.8% of the population (and accounted for 91.2% of the population increase). Texas' population is also seeing increasing diversification and aging. As compared to all the other states in the nation, Texas has the third largest Anglo population (11,074,716), the second largest African-American population (2,421,653), the second largest Hispanic population (6,669,666) and fourth largest population of persons from other racial/ethnic groups (685,785). Texas population, like that of much of the rest of the nation, will continue to age and to have nearly 1 in 5 persons who are 65 years of age or older by 2040 compared to fewer than 1 in 10 in 2000. The issues of aging and diversification of population are also clearly seen in the relationship between youth-status and non-Anglo status. Sixty percent of Texas' population aged 5 years and younger and 57% of the total population less than 18 years of age are non-Anglo. Texas is ranked 45 nationally in the number of person's aged 25 and older who completed high school and of the 1.8 million students in grades 7-12 in 1990 approximately only 1.0% dropped out of the public schools. Texas socioeconomic and service structures will continue to be challenged by a population that is larger, older, and increasingly diverse. Texas population is expected to experience the emergence of a new numerical majority. Population changes, coupled with Texas' size and complexity will challenge Texas' resources during this century. **//2004//**

Economic Factors

/2004/ Continuing the trend from last year's update, Texas' unemployment rate remained stable, albeit higher than those reported just a few years ago. According to the Texas Statewide Labor Market Analysis; the seasonally adjusted unemployment rate in Texas for May 03 was 6.8%, the highest rate reported in Texas since May 1993. May 03 unemployment rates ranged from a low of 1.0% in Kenedy County (Region 11) to a high of 29.5% in Maverick County (Region 8). 15 of Texas' 254 counties (5.9%) reported double digit unemployment rates ranging from 10.1 to 29.5. East Texas counties, as well as the Texas-Mexico border, continued to have significant problems associated with

unemployment. Most reports about Texas' economic picture indicate that the Texas jobless rate may have peaked and will likely see improvement in the near future. **//2004//**

Current Poverty Rates

/2004/ In FY 03, According to the HHSC published Demographic Profile of the Texas Population Living in Poverty, 14.9% of Texas' population lives at or below poverty, showing only a slight increase from the 14.7% reported in 2001. The issues of poverty continue to challenge state resources and impact overall health status. Of those living "in poverty," while Hispanics are proportionately the largest group in poverty (59.8%) they are only represent about 34% of the general population. Anglos and others represent 26.4 of those living in poverty and about 55% of the general population. African-Americans represent 13.8 of those living in poverty, but represent only 11.5% of Texas' general population. Those aged less than 18 years of age represent 41.5 of those living poverty, while those aged 65 plus represent 8.4% of those living "in poverty." Employment status, while classified as "in poverty," with 37.4% reporting that they are employed, 7.7% reporting unemployment, and 54.9% reporting that they are not in the labor force. Forty-nine percent have less than a high school education, with only 7.9% reporting a college or higher-level degree. Over 42% of those living "in poverty" have either both parents or the mother present in the home. Health care coverage remains a critical need for those living in poverty and according to the same reports 57% of those living "in poverty" in 2001 reported some health insurance coverage during 2000. **//2004//**

Texas Health Insurance Coverage Rates

/2004/ Based on May 03 HHSC statistics, close to five (5) million (4,959,829) Texans, or 23.5% of Texas' total population, report no health insurance. This represents a 2.1% increase over FY 2001 reported information. This slight increase may be attributed, in part, to Texas' sluggish economy, loss of overall job in the state and increase unemployment. The without health insurance population often turns to the public or not-for profit private sector for basic preventive and acute health care. Of these five million individuals, approximately 1.3 million (27%) are under age 18. Hispanics continue to be the largest segment of the uninsured population (59%), followed by Anglo/Other (29.8%), and African-Americans (11.2%). Educational attainment for this population is consistent with those reporting poverty status, with 41.3 of those without health insurance having less than a high-school education and approximately 8.9% reporting a college or higher-level degree. Of those without insurance, 65% report being employed. **//2004//**

Health Professional Shortage Areas

/2004/ Texas covers approximately 263,00 square miles and has 254 counties. In 03, 49.6% (or 126 of Texas' 254 counties) are designated as HPSA for primary care and 76 (or 29.9%) designated as HPSA for dental care and treatment. While the number of Medically Underserved Areas (MUA) for whole counties remained stable at 176, the number of partial county MUAs increased to 83 (in 48 counties). Texas currently has 67 local health departments that receive state funding and approximately 84 local health departments that do not receive state funding. Of Texas 254 counties, approximately 150 (or 59%) have no local public health presence but receive public health services by TDH regional offices. **//2004//**

/2004/ These dynamic factors coupled with the department's existing priorities indicate an environment in which there are many opportunities to improve the health status of women and children. Texas is undertaking many activities that may improve the overall health status. **//2004//**

Major State Policy Issues Related to Maternal and Child Health

The State has several priority areas related to maternal and child health and the Title V Program plays an important role in developing and implementing these legislative and agency policy initiatives.

/2004/ The 78th Texas Legislature adjourned on Tuesday, June 2. A total of 5,592 bills were filed during the session. Ten of TDH's 14 initiatives passed. TDH tracked over 777 bills throughout the session and with as many as 126 having a definite impact on department operations and programs. **// 2004//**

Title XXI: Children's Health Insurance Program (CHIP)

With the passage of Title XXI, Texas began planning and implementation of a state children's health insurance program. Texas has implemented CHIP in two phases. Phase I became effective July 1, 1998, as a Title XIX Medicaid expansion to extend eligibility to children ages 15 to 19 at or below 100% federal poverty level (FPL). With Phase I, the Texas Medicaid Program covers children from birth to 1 year of age up to 185% FPL, ages 1 through 5 up to 133% FPL, and ages 6 through 18 up to 100% FPL. CHIP Phase II is a state-designated program targeted to children ages 0 through 18 years of age at or below 200% FPL who are not otherwise eligible for Medicaid. Texas also covers legal immigrant children who are ineligible for CHIP under federal law because of their immigration status. Because these children are not eligible for the federal CHIP match, their coverage will be financed solely with state revenue. There are several features of CHIP worth noting:

Eligibility is based on income, family size, insurance status, citizenship/immigrant status, and residency. There is no assets test. Eligibility is continuous for a 12-month period.

Cost-sharing applies to all eligible families except for American Indians, including co-pays for families below 100% FPL; annual enrollment fees and co-pays for families between 100 and 150% FPL; monthly premiums and co-pays for families above 150 and at or below 200% FPL.Children must be uninsured for a minimum of 90 days (good cause exceptions will be considered). As of July 1, 02, TexCare has received almost 1 million applications since the beginning of TexCare in April 2000. CHIP enrollment for July 02 is 519,630.

/2004/ CHIP continued to evolve during FY 03. As of June 03, Texas' CHIP enrollment is 512,986. This represents 59.2% of the 886,492 applications received. The renewal rate, accounting for normal attrition, stands at 72.6%.

The Texas Legislature in their recently completed 78th Session directed several significant changes in CHIP policy. While coverage continues for all currently covered populations (including state-funded populations) and the eligibility levels are maintained at 200% of the FPL changes in program eligibility and coverage will have an impact on the health of children in Texas. These changes include: eliminating deductions to income so that eligibility is based on gross income; restriction of eligibility for families at or above 150% of FPL to those will assets within allowable levels; allowing for cost-sharing (i.e., co-pays and monthly premiums); changes in continuous eligibility from 12 to six (6) months; establishment of a 90-day waiting period between eligibility determination and coverage; reduction of provider payment rates (5%); and establishment of a preferred drug list and prior authorization for those drugs not on that list.

Several specific exclusions were made from the benefit package and include dental, chiropractic and allergy services; vision care; and eye glasses. Several benefits including durable medical equipment, home health care, physical therapy, behavioral health services and audiology were also excluded, but may be restored if a cost-neutral method of funding can be found. Timelines for implementation are staggered, but many are expected to be in place by September 2003. **//2004//**

Medicaid Managed Care

Texas currently provides services under the Medicaid managed care program in the 8 service areas, primarily centered in major metropolitan areas. These service delivery areas cover 43 county areas. As of July 02, a total of 767,581 clients were enrolled in Medicaid managed care. These clients are enrolled in either a health maintenance organization or the Primary Care Case Management (PCCM) model. As of July 02, 66% of clients were enrolled in HMOs and 34% were in the PCCM plan. The 76th Texas Legislature imposed a moratorium on

expansion of Medicaid Managed Care pending a full evaluation and report to the 77th Texas Legislature in January 2001. That report was submitted and the moratorium was lifted following the 77th Texas Legislature. In response to cost-containment measures passed by the 77th Legislature, HHSC proposed the expansion of the PCCM program the remainder of Texas counties, where Medicaid managed care has not been implemented.

Another significant cost-containment measure passed by the 77th Legislature involves co-payments/cost-sharing in Medicaid. Texas recently submitted a proposal to CMS that is currently under review. It would impose a voluntary co-payment of $3 for emergency services, 50 cents for generic medications, and $2 for brand name medications in State Fiscal Year 03. In Fiscal Years 04-05, the co-pays would vary based on FPLs. This would impact both fee-for-service and Medicaid managed care recipients.

/2004/As of July 03, of Texas' 2,247,439 Medicaid recipients, 1, 099,677 or 49% are enrolled in a Medicaid Managed Care model, as opposed to the 767,581 clients enrolled as of July 02. Again, this may be attributed to the impact of simplified eligibility coupled with an existing sluggish economy. As with CHIP/TexCare legislators made over 19 significant changes in Medicaid policy. While coverage continues for all children currently eligible and the continuous eligibility period remains at six months, significant changes include: establishment of enhanced asset verification; cost sharing; enhance compliance with personal responsibility agreements; and prior authorization requirements for high-cost medical services; and discontinuation of coverage for adult pregnant women over 158% of the FPL as well as for clients with incomes above 17% of the FPL (medically needy). Legislative changes also discontinue coverage for certain optional medical services for adults over age 21 including eyeglasses, hearing aids, podiatric, chiropractic and some psychological services. Legislation also directs the implementation of: disease management efforts; a preferred drug list and a four-brand name and 34-day brand supply limit for certain clients; an estate recovery program for Medicaid expenditures; decreased reimbursement rates (by 5%) for acute care providers as well as for non-acute providers (2.2% to 3.5%) such as nursing homes, community care providers and ICF-MR providers. While the changes are expected to save resources on the Medicaid funding side, the state may likely see a shift in the demand for services to other funding sources, such as the existing resource challenged Title V funding stream. Though a plan and rules written to implement the noted co-pays, pharmaceutical companies filed an injunction against the state to delay implementation of the noted co-pays. The state decided to repeal the rules and implementation of co-pays has not yet occurred. **//2004//**

Texas Kids Count 2000 indicates many families who need assistance and are entitled to public assistance program, were not receiving services. It also reported a decline in participation of many social services from 1995, prior to the implementation of the welfare reform law, to 1999, after its implementation.

Social services showing a decline included Medicaid, Food Stamps, and TANF. While a direct causal relationship cannot be determined, factors related to eligibility and enrollment procedures, burdensome administrative requirements, and fear of problems with immigration status could have contributed to a decline, along with Texas' strong economy during that period.

Texas Kids Count 2000 reports the following changes for the period 1995 to 1999:

Despite the fact that no changes were made to Medicaid eligibility in Texas as a result of welfare reform (and, in fact, Medicaid eligibility was expanded with CHIP Phase I), Medicaid enrollment dropped 20% from 1995 to 1999. The number of children in Texas who left TANF Medicaid from 1996 to 1999 (270,689) was matched by a growth of 49,203 in the income-related children's Medicaid groups (18% of the decline in TANF).

Between 1996 and 1999, the percent of poor children in Texas receiving Food Stamps dropped from 80% to 60%. Texas has seen a 47% decline in its TANF caseload between 1994 and 1998, a decline that is not fully explained by an improvement in the poverty rate. Census data shows that 18% of Texas children live in a family with one or more non-citizen parents. Anecdotal evidence suggests that many families avoid using benefits for which they are eligible because they fear enrollment would create immigration problems for a family member.

However, caseloads have been increasing since those figures were reported, and the economy has weakened. HHSC reports that Medicaid caseloads have increased since FY 2000 and are projected to continue to increase through FY 03. Most of the caseload increase is in the children's categories. The 02 Kids Count Data Book reports that Texas' median income for families with children ($40,700) ranks last among the five largest states, and is more than 15% below this measure for the nation as a whole ($47,300). It also shows that despite comparatively higher rates of work participation by Texas families, a higher proportion of the state's children live in working poor families (measured in the report at 150% of the federal poverty threshold and where at least one parent works at least 40 hours per week for at least 50 weeks per year). In Texas, 20% of children live in working poor families, compared to 15% nationwide. The proportion of Texas children in working poor families exceeds percentages in California (19%) New York (13%), and Florida (16%).

/2004/ The continued implementation of Medicaid simplification and the dynamics the state faces because of financial difficulties require that Texas leaders and policy makers be cognizant of how it compares nationally with other states in some key indicators. The 03 Kids Count Data Book reports that Texas are least likely (nationwide) to have health insurance, the most likely to live in poverty and highly likely of dropping out of high school and giving birth as teenagers, overall

showing Texas lagging behind most other states in a range of indicators of child welfare. Texas' child poverty rank slipped from 36th (with 22% living below poverty) in 02 to 44th in 03. While the median family income of families with children increased to $42,700, more than 1.03 million Texas children, about 21% of Texas' child population are estimate to be living in families with incomes below the FPL. Texas ranks 40th with 22% of its children lacking health insurance compared with 12% nationally. Texas statistics report that 23.5% of children do not have health insurance. Texas ranks 9th in the nation (and better than national averages in infant mortality rates with a rate of 5.7 infant deaths per 1,000 live births. Teen pregnancy rates remain high for 15-17 year olds, with 42 births per 1,000 to rank Texas 49th in the nation. High school drop out rates (13% of teens aged 16-19) ranked 47th highest. In Texas, the percentage of poor people exceeds the national poverty rate, and Texans make up almost one-tenth of the whole nation's poor population. The very poorest communities in the nation, according to the US Census Bureau, are in Texas, specifically along the Texas-Mexico border. The state of women and children's health in Texas is dynamic and resource challenged; finding new and better ways of financing the health structure in Texas will continue to be a priority. The challenge of this environment will be a focus of next year's five year needs assessment and may lead to addressing changing needs in a dynamic environment. **//2004//**

Tobacco Settlement

The 77th Texas Legislature appropriated $9 million for each year of the FY 02-03 biennium in earnings from the permanent fund for tobacco education and enforcement. However, due to reduction in earning only $7.5 million was available from the endowment. An additional $5 million was appropriated by the state legislature. /2004/ The 78th Texas Legislature appropriated approximately $5 million for each year of the FY 2004-2005 biennium in earnings from the permanent fund for tobacco education and enforcement. **//2004//**

TDH Priority Initiatives Related to Maternal and Child Health

Under the leadership of the Texas Legislature, the Board of Health and TDH executive management, TDH and Title V program have defined several key policy and systems initiatives for women, children and youth, and children with special health care needs. These policy and systems initiatives are intended to provide a platform designed to lead to improvement in health outcomes for women and children, including children with special health care needs. Children and women's key policy and systems initiatives include: Children's, Women, and CSHCN Initiatives.

Children's Health Initiatives

Obesity Prevention and Fitness Promotion.

The increasing rate of overweight children is a serious public health concern. Data from 2001 indicate that school-aged children in Texas are more overweight than children in the U.S. as a whole. The data reflect that the problem is greater for boys than girls and for younger children (4th graders vs. 8th and 11th graders). There is also a significant concern for minority children, with about 30% of 4th-grade Hispanic boys and African-American girls being overweight. Individual behavior change is at the core of all strategies to reduce obesity. However, such change can occur and be sustained only in an environment that provides opportunities for healthy food choices, regular physical activity and community and family involvement. The TDH Commissioner has identified the promotion of healthy eating and regular physical activity as one of TDH's top priorities, requiring the state's immediate attention. TDH has a three-year grant from CDC to conduct statewide planning activities and has convened an external Obesity Task Force to develop goals, objectives, and strategies to prevent obesity in Texas.

/2004/ Prior to 02, programs across TDH, had never undertaken a coordinated, agency-wide planning process around the issues of fitness, nutrition and obesity prevention. In FY 03, an operational plan describing how TDH programs would collaborate internally and externally to address the increasing rates of obesity though fitness promotion and to address how collaborative program efforts would begin work towards the goals of the Statewide Obesity Taskforce's Strategic Plan for the Prevention of Obesity in Texas" was developed by the TDH Nutrition and Physical Activity Workgroup (NUPAWG). These goals focused on: increasing awareness of obesity as a public health issue; mobilizing families, schools and communities to create opportunities to chose lifestyles that promote healthy weight; promoting polices and environmental changes that support healthful eating habits and physical activity; and monitoring obesity rates and related behaviors and health conditions for planning, evaluation and dissemination activities.

NUPAWG identified gaps in essential public health services related to the issues of preventing obesity and promoting physical activity and set out to develop action steps TDH should take to begin filling the identified gaps.

Of the 26 proposed actions steps, 16 of the actions were selected as high priority according to group defined criteria. Highlights of the plan included

- development of unified and consistent messages through TDH on the issues of obesity, nutrition and physical activity;

- development of a dissemination plan for TDH-approved data on the issues to increase awareness of the extent of the problem and its outcomes;
- establishment or continuations of collaborations with the state education agency to develop mutual physical activity and nutrition plans;
- development of partnering to plan and implement a coordinated, comprehensive, multi-dimensional fitness promotion campaign that will connect programs and trigger community action; and requirements for TDH-funded community projects to ensure the inclusion of environmental change activities or interventions;
- facilitation of collaboration among other groups that promote same issues;
- establishment and strengthening of community level capacity enabling communities to identify issues in their own community that create barriers to solving the issues

Subcommittees were formed around each of the 16 priority action items. NUPAWG's long-term and ongoing efforts will ensure the ongoing coordination of planning for the use of our resources allocated to nutrition, physical activity and obesity prevention, that no duplication of effort around these activities exists; that resources are leveraged to extent possible; that there is consistency in messages and that fitness promotion efforts are infused into all relevant TDH programs and services. The Texas Legislature did not approve a requested increase over base funding for coordinated school-based interventions in this priority area. Activities on nutrition and physical activity are already components of the Coordinated Approach to Child Health (CATCH) program as implemented in Texas in 728 schools so even though the increased funding request was not approved important education and information sharing in this area will continue. **//2004//**

/2004/ Significant Bureau of Nutrition Services (BNS) resources during FY 03 were dedicated toward an interim study on nutrition and health in public schools as mandated by the 77th Texas Legislature. The major charge to this committee was to hold hearings throughout Texas to determine the nutritional content and quality of foods and beverages served to public school children; evaluate the short and long-term financial, psychological and physiological impact of obesity in public school children; asses the academic, emotional and health value of a universal breakfast and lunch program; and evaluate school contracts relating to competitive food products and vending machines. In March 03, TDH submitted a new application for a 5-year funding period to the CDC-P in order to continue state nutrition and physical activity initiatives to prevent obesity. //**2004//**

Immunization Rates

The importance of maintaining high levels of immunizations cannot be overstated as a public health objective. State leaders have expressed concern that Texas immunization rates for preschool-aged children are lower than the national average. TDH's Commissioner directed that TDH's Bureau of Immunization and Pharmacy Support increase immunization levels for two-year olds to 90% by December 2005. /2004/ Immunization rates in Texas, according to the 2001 National Immunization Survey show that Texas ranks 42nd among the 50 states in vaccinating infants 19 through 35 months of age. The immunization rate for Texas is now 74.9%, a 5 percentage point increase from the previous year. TDH chartered the Internal Immunization Improvement Workgroup in August 02 to identify opportunities to unite TDH resources and overcome internal barriers, enabling TDH to improve immunization levels among Texas' child and adult populations. TDH created the internal workgroup to build on external stakeholder meetings conducted earlier. Two plans emerged from these efforts " A Statewide Plan to Increase Immunization Rates in Texas (9/02) and TDH 03-04 Immunization Improvement Plan Recommendations (11/02). Four objectives (developing and implementing operating procedures considering industry best practices, development of an intra-agency standard for communicating immunization related information, clarification of roles, responsibilities and expectations between the central and regional offices regarding immunization activities and maintenance of an immunization database serving as a public health tool for all programs) resulted from this process. The 4 objectives had 20 action steps associated with them ranging from a business operations review of the Immunization Division to development of a systems model of TDH immunization operation. An Immunization Improvement Project resulting in definable action steps and timelines began in April 03 and a report and action plan will not be complete until September 03.

/2004/ During FY 03 the Immunization Division embarked on other activities designed to enhance the delivery of immunizations in Texas. During July 02, a contract to package and ship vaccines directly to currently enrolled Texas Vaccine for Children (TVFC) providers sites across the state began. Other activities include an unprecedented approach and commitment to reminder and recalls for immunizations. TDH has also contracted with the Texas Medical Foundation to conduct annual site visits of all TVFC clinics. The site visits are designed to improve the quality of immunization practices in TVFC provider sites. The ultimate impact these efforts will have on improving immunization service delivery and ultimately rates in Texas is yet to be studied. **//2004//**

Women's Health Initiatives

During the 76th Texas Legislative Session, a proposal was introduced to fund a women's health program at TDH. The proposal, the Texas Campaign for Women, called for additional funding for comprehensive women's health services

and was supported by a wide variety of organizations, agencies, and associations. Although the proposal never left legislative committee, the Texas Campaign for Women increased awareness of the need to provide and coordinate health programs for women of all ages. Following the legislative session, TDH initiated an evaluation of the organizational structure of the women's health programs across TDH. A reorganization plan for TDH was approved, which included the development of a new Bureau of Women's Health (BWH). Creating a new bureau served to highlight women's health issues and to realign women's health programs across TDH under one administrative entity. For FY 03, BWH will continue to focus on promoting comprehensive women's health for Texas. BWH has requested funding from the HRSA to implement a three-year initiative to enhance the state's capacity for promoting the integration of women's health services for priority populations.

/2004/ A grant from HRSA was awarded in September 02 to implement a 3 year Texas Comprehensive Women's Health Initiative to enhance the state's capacity for promoting the integration of women's health services for priority populations. In FY 03, BWH established a formal state-level planning workgroup for women's health and began planning and provided support for the development of two women's health services planning workgroups at the regional level. El Paso and the Rio Grande Valley, as the sites of these pilots, will work to facilitate local leadership and decision-making and to improve the overall integration of services for women. **//2004//**

/2004/ A major initiative under BWH has been the implementation of regional perinatal health systems to improve perinatal health outcomes for women and infants. The regional perinatal health system has been supported by the Pregnancy Risk Assessment and Monitoring System (PRAMS), implemented statewide in May 02. These two initiatives are being coordinated to be tools and vehicles for directing improvements in systems of care and, subsequently, health outcomes at the community level. **//2004//**

/2004/ The BWH has undertaken the leadership role in several initiatives related to women's during FY 03 and will continue those efforts into FY 04. An ongoing group of internal and external representatives, the Teen Pregnancy Prevention Workgroup, meets monthly to address teen pregnancy issues and has recently completed a best practices document and is in the process of finalizing a strategic plan. The Violence Against Women Project (funded by CDC-P) implemented an internal and external stakeholder workgroup and is in the process of surveying various stakeholders on practices around domestic violence. The HRSA funded Texas Comprehensive Women's Health Initiative (TxCWHI) established an internal Women's Health Network to build capacity among program staff dealing directly or indirectly with women's health issues. TxCWHI selected two public health regions, El Paso and the Rio Grande River Valley, to focus their efforts in facilitating the development of comprehensive women's health care delivery systems at the local level. Region 11 was chosen

during the grant proposal development due to its strong interest in women's health, the existing infrastructure, and its proximity to the US/Mexico border. Region 10 was chosen by the Women's Health Network due to its interest in the project, and its demographic similarities to Region 11. Implementation in the regions will not begin until September 03, however representatives of each region are participating in the Women's Health Network and the planning process. **//2004//**

/2004/ There are many other activities that will be initiated and carried forward to FY 03 to support women's health.

Strategic Planning and Policy and Program Development

The BWH is collaborating with various partners to: conduct a strategic plan for breast and cervical cancer control in Texas; preventing violence against women in Texas; promoting best practices in teen pregnancy prevention; and assessing the state's capacity to conduct maternal mortality reviews. **//2004//**

/2004/ Activity in these areas continues. BWH received funding from the CDC-P.to conduct a survey of entities across the state to assess best practices and policies regarding the prevention of violence against women currently in place. The statewide advisory group on domestic violence has been convened to develop the strategic plan. Collaborate efforts have yielded a teen pregnancy prevention best practices guide. A needs assessment is being planned for a statewide mortality review process. Other significant projects involving infant mortality, fetal alcohol syndrome and male involvement are also underway. **//2004//**

Telemedicine: The 77th Texas Legislature passed Rider 67 appropriating funds to expand existing telemedicine systems for low-income women in an urban county hospital district and a rural not-for-profit health facility. Through a competitive bid process, BWH awarded funds in FY 02 to 2 health entities (one urban, one rural) to expand gynecological and obstetrical sonogram and ultrasound telemedicine services. It is expected this model for telemedicine and women's health could be expanded to other areas of the state with women's health provider shortages.

/2004/ This project has been completed and both entities successfully implemented their telemedicine programs. Both sites have the necessary equipment and have implemented services. Both are actively providing services to the women in their communities. **//2004//**

Women's Health Services Implementation

Medicaid Family Planning Services: Title V staff and other TDH programs will be responsible for implementing an expansion of Medicaid Family Planning services

in FY 03 as part of a women's health waiver under development by the HHSC and TDH. The proposed expansion will significantly increase the number of women ages 18-44 eligible for Medicaid covered family planning services and have an impact on current family planning programs including Title V, X, XX, and XIX.

Breast and Cervical Cancer Treatment Services: The Breast and Cervical Cancer Control Program providers will be the key link in enrolling and qualifying women for treatment under Medicaid for breast cancer or cervical cancer, as authorized during the 77th Legislative Session. This legislation will be implemented by FY 03.

/2004/ During FY 03, Title V staff and other TDH programs assisted with the development of the expansion of Medicaid Family Planning services in FY 03 as part of a women's health waiver under development by the HHSC and TDH. Due to funding limitations, implementation of the waiver was put on hold. **//2004//**

Public Awareness and Professional Education

Outreach to Asian/Pacific Islander Women: BWH will sponsor a conference in November, 02 to assist health care providers to work with Asian American and Pacific Islander women to participate in screening for early detection and treatment, particularly focusing on breast and cervical cancer and osteoporosis. This will be the first program sponsored by TDH that will exclusively address priority health concerns of Asian and Pacific Islander women.

/2004/ The TDH Breast and Cervical Cancer Prevention program, the TDH Osteoporosis Program and the National Asian Women's Health Organization, jointly sponsored the Asian Pacific Islander Women's Health Conference, "Cultural Tools Beyond Communications," in June 03. The conference goal was to provide participants with tools and strategies enabling them to motivate Asian/Pacific Islander women to seek screening for early detection and treatment of breast and cervical cancer. The 79 participants included speakers and TDH staff members, and health and social care providers and contractors who work with this population. **//2004//**

Sexual Coercion Prevention: BWH is testing a new website developed by the Family Planning program to train family planning contractor staff to screen and provide counseling to adolescents and teens to identify and prevent sexual coercion. After testing is completed in FY 02, the web page will be available in January 03, with continuing education credits for family planning staff. The website will be available to a broader audience later in FY 03 if the project is determined to be of benefit to contractors.

/2004/ During FY 04, BWH tested the website mentioned in the previous update and in January 03 the website went live, providing continuing education credits

for family planning staff. Access to the site is restricted at this time to family planning contractors. FY 04 plans include broadening the audience for the web site pending a determination that the project is beneficial to contractors and adding a counter to the site to determine the number of hits. **//2004//**

Breastfeeding Summit: BWH staff are providing support to the Bureau of Clinical and Nutrition Services to conduct the Texas Breastfeeding Summit in San Antonio in FY 03.

/2004/ While the Texas Breastfeeding Summit did not occur due to funding limitations, breastfeeding promotion activities and an active partnership with WIC continue. Breastfeeding promotion materials and services are provided through WIC clinics, Title V providers, and a variety of other partners. The BWH oversees the Mother Friendly Workplace Initiative that assists businesses in providing breastfeeding services to their employees and continues collaboration with WIC staff on materials development and review and in implementing special projects such as the awarding of a contract for the distribution of breast pumps through WIC local agencies. BWH staff provides breastfeeding training to contractors and stakeholders as well as well as promoting such programs as the Texas Ten Steps Hospital Program. **//2004//**

Healthy Starts Conference: BWH staff are providing support to the San Antonio Healthy Starts project in planning for the FY 03 conference focusing on postpartum depression.

/2004/ Title V continues support to the Texas Health Start Projects for Texas Healthy Start Alliance activities. TDH continue to meet on a quarterly basis to share information. and participated in planning a conference on pre-term birth in January 2004. TDH staff will continue serving on the planning committees for the DHHS Region VI Health Start Conferences. **//2004//**

Ovarian Cancer: BWH has developed a proposal to initiate a new professional education program to promote health professional's awareness of ovarian cancer. A request for funding has been submitted by TDH to the Centers for Disease Control and Prevention to provide this new program to contractors.

/2004/ Title V has developed a proposal to initiate a new professional educational program to promote health professional’s awareness of ovarian cancer. A request for funding was submitted by TDH to the CDC-P to provide this new program to contractors, but to date, there has been no response. **//2004//**

Children with Special Health Care Needs Initiatives

The CSHCN program has undergone significant change since 1999. Legislative mandate directed TDH to change the Chronically Ill and Disabled Children's Program from a categorical, diagnosis-restricted program to one more

comparable to CHIP or Medicaid. The new CSHCN Program was to cover additional children who were otherwise uninsured or under-insured. The redesigned program was also to provide family support services not covered by Medicaid, CHIP or traditional insurance programs. This major system redesign included extensive involvement of consumers, providers, advocates, and other stakeholders. Full implementation of the redeveloped program began in July 01. Concurrently, the state's CHIP was implemented in May, 2000. Some children 18 and under who were in the CSHCN Program were also potentially eligible for CHIP. Accordingly, as of September 2000, application for and enrollment in CHIP was made a condition of CSHCN eligibility.

Due to a decrease in appropriated funds, higher expenditure levels for current clients and services, smaller numbers of CSHCN children being eligible for CHIP than originally projected, and other mandated changes to the program, the CSHCN Program faced projected funding shortfalls in fiscal years 02 ($5.9 million) and 03. To address this issue, the Department asked HHSC to conduct an independent review of the program. Eighteen recommendations resulted. If totally implemented, cost savings in FY 02 would be $5.6 million and $8.1 million in FY 03. An 11-member TDH implementation team, including stakeholder representatives, was appointed to review the recommendations and develop a plan for implementation.

Actions related to recommendations were taken. For example, reductions in CSHCN staff have been made, and a waiting list for new clients seeking services for medical and family support services has been initiated. Reductions or limits to the program's health benefits and family support services requires were necessary and required program rule changes. To that end, the CSHCN staff is in the process of drafting new program rules. Further efforts to address the budget shortfall include assessing and analyzing the possibilities of contracting in existing risk arrangements with health plans in larger groups (Medicaid, CHIP) to improve the risk rating for this group of clients, and the establishment of a separate nonprofit CSHCN foundation.

/2004/ The CSHCN program has experienced major budget concerns over the current biennium (FYs02/03) and continues to have a waiting list for services. Approximately 150 clients with urgent need for health care benefits were removed from the waiting list in February 03 but approximately 1200 children remain on the wait list. The program has seen reduction in staff and awards to contract service providers. During FY 03, the CSHCN staff and the CSHCN Advisory Committee spent much time and effort on developing rules for budget alignment. This process involved extensive stakeholder input. Rules changes implemented in March 2003 establish the program’s methodology for budget alignment. It is expected that budget constraints will continue through the coming biennium (FY 04/05).

Changes in federal legislation that may impact the CSHCN Program include: the Lifespan Respite Care Act which would authorize $90 million in competitive grants to states and other eligible entities for community-based respite care services for caregivers of individuals with special needs of all ages; and, the Family Opportunity Act that would amend the Social Security Act to allow states to provide families of children with significant disabilities the opportunity to purchase health care coverage under the Medicaid program. **//2004//**

/2004/ FY03 has also been a time characterized by ongoing budget constraints. The waiting list continues and new program rules were written through a process that included extensive stakeholder involvement. The new rules, became effective March 03 and outline methods for program budget alignment. The rules were changed to establish a process by which the program shall align its budget yearly, especially when estimated amount of funds needed by the program exceed appropriated funds and other available resources. The rules include methods for the program to use in placing children on the program's waiting list and the criteria and protocol to determine "urgent need for health care benefits" so that they may be removed from the waiting list as funds become available. There is now a clarified public process for placing children on and off the waiting list for services. In February 03 about 150 clients were removed from the waiting list, however approximately 1,200 children are still waiting to receive program benefits. During FY 03 several members of the CSHCN Advisory Committee organized a separate foundation, the Rusty Foundation, exclusively for charitable, educational, and scientific purposes, including the solicitation, acceptance, and management of private donations for use in programs relating to health care, transportation, family services, any health-related services, or essential public health services for children and their families. **//2004//**

Health Disparities

This section affects both women and children's populations. In an attempt to address growing concerns about health disparities, the 77th Legislature passed HB 757 that established the Health Disparities Task Force. The task force is charged with the responsibility to consult with TDH in eliminating health and health access disparities in Texas among multi-cultural, disadvantaged, and regional populations. The establishment of the task force makes the state of Texas one of the first states in the country to legislatively mandate a task force to look into the differences between the health of various groups. The task force members met twice this year in April and June,02 and efforts are being made to determine top health disparity priorities and devise action plans accordingly. This is a very exciting time for the Title V program to have all TDH related programs' efforts and resources together in a uniform intervention plan to address top priorities in heath disparities, as identified by the task force.

/2004/ The task force met twice in FY 03 and now meets quarterly, with their next meeting scheduled in August 03, at which time they will discuss the impact of

recently passed legislation on the reduction of health disparities in Texas. The task force submitted an executive report to the Texas Legislature in February 03. This report included legislative recommendations as well as recommendations for TDH regarding addressing health disparities across the state. Recommendations to the legislature included:

- support for legislation addressing preventing health care (especially related to tobacco prevention);
- preventive intervention (especially in the areas of obesity and physical activity); and
- several recommendations related to insurance, managed care and access to care, for example:
  - increased funding for Medicaid, CHIP;
  - enhanced regulation and oversight over HMOs;
  - stricter enforcement of current "prompt" pay laws;
  - and support for improving trauma care systems.

The task force also recommend that TDH

- design, implement, and evaluate culturally competency strategies throughout its structure organizationally (recruiting, promoting and retaining a more diverse management and administrative structure);
- programmatically (reflecting a demonstrated competency in the values, language, cultural norms, and health literacy of the populations being served);
- and by developing policies that advance cultural competency among all levels of TDH and TDH contracted providers through training, policies and procedures, professional development, and funding patterns.

The task force also recommended legislation for medical malpractice tort reform. The task force published an online brochure during FY 03 on health disparities in Texas. The task force also serves a steering committee member in the Texas State Strategic Health Partnership, as detailed in the needs assessment section. Future operations of the task force due to legislation passed during the 78th (HB 2292) session limiting the number and scope of task forces and advisory committee is undetermined at this time. **//2004//**

/2004/ Texas' public health environment will continue to evolve and both state and department leadership must position themselves to proactively respond those changes. Consideration for many of the topics covered in this overview will be key components of the next five year needs assessment and the action plan resulting from those efforts. **//2004//**

B. AGENCY CAPACITY

In FY02, the Texas Title V Program provided Title V and general revenue funds for direct, enabling, population-based and infrastructure building activities around preventive and primary care services for pregnant women, mothers, infants, children, adolescents and children with special health care needs. The majority of MCH services are provided through contracts with local providers including local health departments, universities, FQHCs, hospital districts, school districts, local coalitions and individual providers. Contracts are awarded through a competitive request for proposal process. In areas of the state where no local contractors exist, MCH direct services are provided by the Public Health Regional Offices through their clinic sites. MCH direct services are provided to women, infants, children, and adolescents who are at or below 185% FPL and not eligible for Medicaid and CHIP. MCH direct service providers are required to screen for Medicaid/CHIP eligibility and to refer those individuals who are potentially eligible.

Many of the MCH contractors are also WIC, Family Planning (Titles X, XX, and XIX), Medicaid (prenatal care, case management for high-risk pregnant women and infants), Texas Health Steps (EPSDT), Primary Health Care, Breast and Cervical Cancer Control Program and/or HIV/STD providers and, as such, are able to provide improved access to a more comprehensive array of services to women and children and families.

In early February 01, Title V Program announced the availability of funds for grants targeted toward improving the health of infants, women, children and adolescents starting in September, 2001. Grant requirements were released in a 3-year competitive request for proposals (RFP) that consisted of two types: Fee-for-service direct health care and population-based infrastructure building services. Applicants could apply for both types or one type only. Currently, a total of 76 contracts for MCH fee-for-service are funded statewide for a dollar amount of about $21 million and 15 contracts for genetic fee-for-service are supported with a total of $1.5 million for array of allowable Title V services categories). In addition, 37 population-based contracts were awarded for a total of $2.3 million. For FY 03, approximately the same number of contracts will be funded for the second-year continuation of the 3-year competitive RFP. As a result of the Title V budget realignment, contract amounts will be reduced approximately $1.7 million (see Section 3.3.2 Other Requirements under Texas Title V Budget Realignment).

/2004/ FY 03 began the second year of a 3-year competitive request for proposals (RFP) that consisted of two types: fee-for-service direct health care and population based infrastructure building services. Only current contractors were able to apply for grants to improve the health of infants, women, children and adolescents starting in September 02. FY 03 was the first year that MCH (prenatal, child health, children's dental, dysplasia) were awarded separate from

family planning services funded by Title V. As a result of the Title V budget realignment, contract amounts were reduced from FY02 awards by approximately $1.7 million. A total of 76 contracts for MCH fee-for-service continue to be funded statewide for a total dollar amount of about $12 million, 54 contracts for family planning for a total of approximately $8.1 million, and 15 contracts for genetic fee-for-service for a total of approximately $1.5 million. In addition, 27 population-based contracts were awarded for a total of $1.6 million. There are nine fee-for-service genetics contractors, for a total of $1,342,000; and three populations based genetic service contracts, for a total of $158,000. **//2004//**

/2004/ Provision of MCH services in Texas continues. Protecting the health of all Texans, including women and children, is at the core of the Department's mission. Services provided by women and children focused programs in a multi-tiered system of infrastructure building services, population based services, enabling services and direct services is a hallmark of the delivery of health services in Texas. For example, the BWH, while not currently involved in the provision of direct services, other than through family planning contractors, has a very strong focus on building capacity of systems to meet the need by development of policies, guidelines and programs addressing the public health needs of their targeted population. Both clinic and non-clinical staff have and maintain a high level of expertise in their chosen fields. BWH staff stay current, leverages resources and links individuals and organizations to relevant programs by establishing, maintaining and fostering both existing and new national, state and local relationships. BWH provides data, data analysis, information, guidance, technical assistance and training to its stakeholders by various means (in person, phone, email, Internet). As with all levels of national, state and local government staff is adapting to workforce and workload issues, and finding creative, lower cost ways of meeting needs. **//2004//**

/2004/ TDH was also awarded a HRSA grant (September 02) to implement a three-year Texas Comprehensive Women's Health Initiative. The initiative's purpose is to enhance the state's capacity for promoting the integration of women's health services for priority populations. During the grant's first year, BWH established a formal planning workgroup for women's health at the state level and initiative and began efforts supporting development of two women's health services planning workgroups at regional levels. Pilots in two areas of the state, El Paso (Region 10) and PHR 11 (Rio Grande Valley) will increase the capacity of providing local leadership and decision making leading to anticipated improvement in the integration of services for women.

Maintenance of ongoing collaborations and the enhanced capacity they afford will continue to be critical to the successful delivery of maternal and child health services in Texas. An important link in Texas capacity to provide services is ongoing collaboration and development of a stronger collaboration between Healthy Start and Title V. As TDH and Healthy Start mutually identified mutual

goals of improving perinatal health outcomes for mothers and children, together they identified activities designed to increase collaboration. Activities planned for FY 04 include holding quarterly meetings for continued planning and collaboration (information sharing, issues discussions, etc), Healthy Start input into the BWH's perinatal systems planning and rules development and implementation, Title V supports the San Antonio Health Start's project in planning for the FY 04 conference focusing on pre-term birth as well as together participating in the implementation of the Region VI 3-year strategic plan. **//2004//**

/2004/ The Child Wellness Division (CWD) programs has aided in providing capacity to provide for and protect the health and safety of all children in Texas has primarily been provided in the past through contractors who tailor their programs for their specific communities. Many CWD programs promote prevention and early childhood intervention through education, many of which are local based. Funding reductions have eliminated many worthwhile programs (i.e., youth health initiative) the local level. However, grants such as Healthy ChildCare America will hopefully sustain an infrastructure for programs that can be further developed in the future.

Programs in the CWD (School Health, Adolescent Health, Audiology Services, Traffic Safety, Take Time For Kids, Vision/Hearing Screening and Abstinence Education) also engage and partner in proactive collaborations with a variety of partners. The most aggressive program to initiate and support collaboration/coordination has been the Take Time for Kids Program as detailed in other sections of this application. Also, a number of school health staff members have been actively involved on various internal workgroups that involve TDH areas (i.e., nutrition, obesity, physical fitness, diabetes, immunizations, etc) to develop plans and implement strategies to further support the health and safety of children both within school settings as well as within Communities. The Newborn Hearing Screening program collaborated with the Texas Interagency Council for Early Childhood Intervention in applying for a grant from CDC-P to enhance the Texas Early Hearing and Detection and Intervention program to increase the number/percentage of infants who receive follow-up outpatient screening and enter intervention services by six months of age. Word on whether this application is funded will arrive in Summer 03. **//2004//**

/2004/ Dental Health and Treatment

Addressing the issue of capacity, TDH must consider the state's capacity to deliver dental services. Coupled with an already existing shortage of dental providers willing to provide services to the those not on private dental insurance and/or private pay patients, several changes were made this legislative session that may dramatically impact the state's capacity to provide access to dental services for Texas' children. For example, the Division of Oral Health's (DOH) budget was reduced by 68% for the FY 04-2006 biennium, leading to almost a

75% staff reduction. Some services such as fee for service dental will be completely eliminated while others, such as proactive education, will be eliminated except for basic oral hygiene instruction given during exams and/or treatment. The DOH also helped establish the original Texas CHIP for dental by assisting in setting rates and policies, however due to a legislative mandate dental coverage for children in CHIP was eliminated. As a result, some Title V monies have recently been redirected to help with establishing an infrastructure of Texas dental services in each region. In addition, dental services will continue to be provided through Title V-funded contractors. **//2004//**

Service Delivery Integration

/2004/How we provide services today to an every increasing client base in a resource static environment remains a challenge that Title V must work to meet. One important effort is that of service delivery integration. **//2004//**

Texas has a twelve-year cycle for the sunset review process in which the sunset review committee makes recommendations to the Legislature regarding whether an agency's functions are still needed and if legislative changes are required. From 1997 to 1999, TDH underwent the sunset review process. The recommendations resulting from the sunset review were legislated in House Bill 2085 of the 76th Texas Legislature. A key requirement in HB 2085 directed TDH to integrate the functions of its different health care delivery programs to the maximum extent possible, including integrating functions of both Medicaid and non-Medicaid health care delivery programs. Functions identified for integration include health care policy development, health care service delivery (medical home), and administration of contracts (including uniform procurement, contracting terms, billing, reporting, and monitoring). The programs identified as "in scope" include the Maternal and Child Health programs (including the CSHCN program), Family Planning (Titles X, XX, XIX), Primary Health Care Program, WIC, and Medicaid. The Associateship for Family Health was identified as the lead for implementing the service delivery integration (SDI) directive.

Service Delivery Integration began by integrating, streamlining, and standardizing policies and procedures of several programs. To support the integration of policies, an automation system, SDI Integrated, Eligibility, and Reporting System (SIEBRS), was developed. A streamlined, integrated contract procurement process for the including a single contract attachment for in-scope programs was also utilized.

/2004/ The SDI project currently maintains 5 pilot contractors (Denton County, Hidalgo County, and Tarrant County Health Departments, Fayette Memorial Hospital and the Tyler-Smith Public Health District. In-scope programs are Titles V, X, XX, Primary Health Care and TB Elimination. All pilot contractors offer Title V services, but not necessarily all of the in-scope programs. SDI contractors for FY 04 will be renewed. Recently completed activities in this area include

continued revision and streamlining of integrated policy manual and business rules for integrated IT systems. By March 1, 2004, because of the accomplishments realized during this pilot, such as reduction in administrative burden and better accountability, the plan is to expand this initiative to all primary health care contractors and eventually to include all contractors such as Title V. **//2004//**

Children with Special Health Care Needs Services

TDH and Title V operate the CSHCN Services Program. The services provided through the CSHCN Program were changed as of July 1, 2001 to remove diagnosis-specific requirements and move toward a health benefit plan more like CHIP. Services are available for children from birth until 21 years of age (except adults with cystic fibrosis, who are eligible for services beyond age 21) who meet financial guidelines and residency requirements. Citizenship and documented immigration status are not required.

The CSHCN Services Program provides health care services including: early identification, initial evaluation and diagnosis; case management, physician visits; hospitalization; orthotics and prosthetics; medical equipment and supplies; nutritional supplements; nutritional counseling; medications; speech, language, physical, and occupational therapy; and meals, lodging, and transportation to receive medical treatment.

The CSHCN Services Program recently underwent a major redevelopment process as discussed in previous sections. Redevelopment has resulted in a program that is open to children meeting the definition of a "child with special health care needs" and not just a specific diagnosis; and a program that is more comprehensive, with broader benefit coverage and the capacity to supplement health care coverage that is inadequate to meet the needs of CSHCN. The CSHCN program also plans to offer an array of family supports, such as respite, when funds are available and currently is maintaining a waiting list for family support services. The CSHCN program will continue to be the payer of last resort, after Medicaid, CHIP, and private insurance.

A waiting list for medical benefits in the CSHCN Program has recently been instituted due to an unanticipated budget shortfall. To address further this budget shortfall, TDH asked the HHSC to conduct an independent review of the program. A five-member team was appointed. Team members interviewed over 60 individuals and conducted an extensive financial analysis leading to a set of 18 recommendations involving administrative functions, contracts and grants, medical services, and financial management of the program. If totally implemented, cost savings in FY02 would be $5.6 million and $8.1 million in FY 03. TDH appointed an 11-member implementation team, including stakeholder representatives from the CSHCN Advisory Committee to review the recommendations and develop a plan for implementing them.

Some of the review team recommendations have already been implemented. For example, reductions in staff have occurred, and, as mentioned, a waiting list for new clients seeking services for medical and family support services has been established. The current scope of health care benefits and family support services are set forth in the program rules which were developed in a time when it appeared there was more funding available for the program. To reduce or limit the program's health benefits and family support services requires program rule changes. To that end, the implementation team is in the process of drafting new program rules. Further efforts to address the budget shortfall include assessing and analyzing the possibilities of contracting in existing risk arrangements with health plans in larger groups (Medicaid, CHIP) to improve the risk rating for this group of clients, and the establishment of a separate nonprofit CSHCN foundation.

/2004/ The Texas Board of Health approved the CSHCN program rules that became effective on March 27, 2003. The rules, as mentioned earlier, were changed to establish a detailed process by which the CSHCN Program shall align its budget annually, especially when the estimated amount of funds needed by the program exceed the appropriated funds and other available resources. The rules now include methods for the program to use in placing children on the program's waiting list and the criteria and protocol to determine "urgent need for health care benefits" so that they may be taken off the waiting list if funds become available. Currently the program has approximately 1,200 children on the waiting list. The impact of the rule changes on the program's clients is that there is now a clarified public process for placing children on and off the waiting list for services.

An intensive effort is now underway by CSHCN staff to operationalize the rule changes. Approximately 30 rules implementation issues were identified and at a meeting of the CSCHN program leadership, issues were grouped into six (6) areas: Definitions and Eligibility; Family Support Services; Case Management; CSHCN Advisory Committee; Budget Alignment; and Quickly and Simply Resolvable (includes those issues that require little or no change, but do need someone to make sure that they conform to the new rules). Team leaders have been assigned to each of the areas and teams formed of cross programmatic representation, representatives from case management, representatives from Information systems, and representatives from TDH regional offices. Each team developed a work plan identifying the steps needed to address their respective issues and a timetable to complete. A Coordination Group meets weekly to insure that work by the teams is supported across all areas and that work plans are integrated. **//2004//**

Case management (or care coordination) services are available to help families to access necessary services. TDH provides these services through CSHCN staff in the TDH regional offices throughout the state. In some locations, contracts with community-based organizations enhance the provision of case

management services. A key purpose is to provide and promote family-centered, community-based, coordinated care, including care coordination services for CSHCN. These programs also facilitate the development of systems of care for CSHCN and their families. The regional and contractual service providers also facilitate the development of new services for CSHCN, thus enlarging the available systems of care for CSHCN and their families. Policy and contract administration for the Title V case management contracts are provided by CSHCN staff. Policy and oversight for the regional and Medicaid case management services other than CSHCN case management (such as Medicaid Pregnant Women and Infants Case Management (PWI) and Medicaid Medical Case Management) are provided by the Case Management Section in the Bureau of Children's Health. Case management/care coordination services are provided to children enrolled in the CSHCN program as well as for other children seeking health care and related services. In 1998 Medicaid Medical Case Management was implemented to provide case management/care coordination services for children and adolescents enrolled in Medicaid. As the number of Medicaid case management providers increases, it is expected that the CSHCN regional staff's direct involvement will decline. The CSHCN regional staff will continue to provide an oversight and quality assurance role for the Medicaid Medical Case Management Program.

Children with SSI have been a special target population for case management outreach for many years, even as other "rehabilitative services" have been increasingly provided through Medicaid. Children with SSI are automatically eligible for Medicaid in Texas. The Social Security Administration contracts with the Texas Rehabilitation Commission (TRC) to conduct disability determinations for SSI. The applications of children aged 16 and under who are determined to be eligible for SSI are sent to TDH, Bureau of Children's Health, Case Management Section, for distribution to the TDH public health regional offices. Regional CSHCN staff contact all families of SSI-eligible children via telephone or mail and arrange for services as needed, facilitating access to the array of Medicaid services.

The CSHCN Program also provides a limited amount of funding for the Purchase of Service Program for SSI beneficiaries. This program purchases services and equipment not available though the Medicaid program or other resources. Van lifts have been the service most requested in the past, but effective May, 2000, a pilot program was implemented to expand services to include minor home modifications (not permanent structure), short-term or emergency respite, special equipment and supplies, and parent training. The current rules for the CSHCN Program built in "family support services" to continue to make such services available for families.

/2004/ Under the new CSHCN rules, family support services are provided as part of the CSHCN program’s health care benefits package, but in situations when there is a waiting list for program services, family support services can be

provided only when they will prevent out-of-home placement of a CSHCN client and/or when provision of the family support service is cost effective for the program. **//2004//**

Development of Systems of Care

Within the Bureau of Children's Health, the Children with Special Health Care Needs Division is responsible for CSHCN-related activities for TDH. Staff members in the CSHCN Division are involved in development activities statewide for the promotion of systems of care for CSHCN. For example, the staff are involved in several initiatives of the Texas HHSC, including the Children's Policy Council, the Long Term Care Waiver Consolidation Workgroup, and the Texas Integrated Funding Initiative.

/2004/ CSHCN staff participated in additional activities that CSHCN staff participate that address systems of care include, but are not limited to, the Texas Council on Developmental Disabilities, the Promoting Independence Task Force, the Children's Policy Council, the Texas Council for Developmental Disabilities, the Interagency Council on Autism and Pervasive Developmental Disabilities, the Medicaid Managed Care State Advisory Committee, the Children's Resource Coordination Group State Team, The Texas Interagency Council on Early Childhood Intervention, and the Traumatic Brain Injury Advisory Council. **//2004//**

The majority of CSHCN services are provided through individually enrolled providers across the state. These providers include, but are not limited to, physicians, dentists, hospitals, outpatient hospitals, occupational therapists, physical therapists, speech-language therapists, home health agencies, pharmacies, laboratories, orthotists, prosthetists, and a number of other specialty care providers. In addition, the CSHCN Program provides case management and other services through contracts in selected areas of the state. For FY 02, competitive Requests for Proposals for Wellness Centers, Direct Services (outreach clinic), and Family-to-Family Partnerships were issued. Four Wellness Centers applicants were funded and now provide inclusive support services and activities, such as career and life planning, nutrition education, health education, recreation, camps, adaptive exercise, and life skills. The model was conceived by the TDH CSHCN Advisory Committee. Two outreach clinics are providing specialty medical care to CSHCN in underserved/unserved areas of the state. One Family-to-Family Partnerships contractor is providing case management and other support services using parents or other family members as case managers. The model incorporates the recommendations by the CPC of the HHSC as well as input from other parents, providers, and advocates. Thirteen case management (including parent case management) and community/family resource services contracts and four population-based community/family resources only contracts were also funded via a continuation application. Examples of community/family resource services include the development of a respite network in rural east Texas, development of resource manuals for

transition planning, information and referrals services, equipment and adaptive toy lending services, and educational workshops for families. Other FY 02 CSHCN contracts included a medically supervised daycare pilot, PKU research project (9 contractors), actuarial services, the Community Resources Coordinating Groups Interagency contract, a parent consultant to the CSHCN Program, and a nurse consultant for service contractors.

At the beginning of FY 02, all 39 CSHCN contracts amounted to about $4 million. Due to budget constraints, the total amount was reduced to about $3,2 million by terminating one contract and reducing other contractors' awards. For FY 03, only 24 out of 38 current contracts will be renewed for a total of close to $3 million.

/2004/ Contracts retained in FY 03 include the community/family resource contracts, the wellness center contracts, case management contracts, the Community Resources Coordinating Groups interagency contracts, two (2) direct service contracts, an additional actuarial contract, and the medically supervised daycare pilot. FY 04 contracts are currently in negotiation and a final dollar amount is not yet available. **//2004//**

Medically Dependent Children Program (Medicaid Waiver)

The MDCP Medicaid waiver was legislatively transferred to the Texas Department of Human Services from its former administrative home in the CSHCN Division. This waiver serves children with significant medical needs and currently provides Medicaid and waiver services to well over 1,000 CSHCN. Efforts of the division staff were focused on making the transition of administrative oversight as family-friendly as possible, hoping to avoid any problems in delivery of services to families. The transfer occurred September 1, 2001.

/2004/ As a result of the 77th Legislative Session, MDCP was transferred back to the Texas Department of Human Services. **//2004//**

Medicaid Managed Care

CSHCN staff have been actively involved for two years in the development of a model for services to children with special health care needs in managed care. This work, under the leadership of the State Medicaid Office within HHSC, has focused on defining CSHCN for the purposes of Medicaid managed care, developing an identification mechanism for use in Medicaid managed care, piloting this mechanism using the definitions developed, and designed quality assurance processes to assure quality care to CSHCN in managed care. This work was mandated by the Texas Legislature (SB 1165). The pilot testing occurred in Bexar County, Texas (San Antonio) and data was collected and analyzed. Modifications to the model will be made based on the results of the

data from the pilot. Eventual statewide implementation may occur, pending completion of the evaluation and modification of the model.

/2004/ This activity has completely transitioned to the HHSC, which is also now the state Medicaid office. Recent activity includes a series of workshops conducted in eight regions during May02. These workshops titled “Case Management and Coordination Care for Children with Special Health Care Needs” targeted the staff of managed care organizations and community-based organizations regarding their respective roles serving CSHCN and to promote communication and coordination among these providers at the local level. The workshops consisted of four sessions, with four major content areas including the identification of CSHCN, definitions of CSHCN, methods for identification of CSHCN in managed care settings and coordination of care and services. The workshops were well received and attended in all regions of the state. A total of 274 persons attended the workshops statewide. Social workers and nurses represented the majority of attendees. The CSHCN workgroup, BexarCare Pilot and the use of the identification tool (FACCT) helped advance the process for the Texas Title V program which has restructured eligibility requirements to a non-categorical identification and eligibility approach for the Title V Program in Texas. **//2004//**

Transition To Adult Health Care

The CSHCN "On the Right Track" project has developed a section of its website focusing on transition issues for people with disabilities. The overall site targets communication between people with disabilities and the individuals who work with them. Staff members have also coordinated with Dr. Albert Hergenroeder, Associate Professor at Baylor College of Medicine and Project Director of the LEAH (Leadership Education in Adolescent Health) Training Program, in the development of a statewide distribution list of people interested in transition issues. In addition, staff are involved in the ongoing development of an interagency Memorandum of Understanding (MOU) regarding transition issues for youth with disabilities and /or chronic illness. At the regional level, CSHCN case management staff and case management contractors work with CSHCN to plan for their transitions to adult health care, education, work, and independence.

/2004/ In June 03, all participating agencies signed the Interagency Memorandum of Understanding regarding transition issues for youth with disabilities and/or chronic illness. Internal to TDH, CSCHN program staff continues to work collaboratively with TDH’s Virtual Office on Health and Disability to raise awareness of disability-related issues across the lifespan in all health program areas**. //2004//**

/2004/ The CSHCN program has taken several active steps to ensure a statewide system of services inclusive of comprehensive, community-based,

coordinated, family-centered care essential for effectively fostering and facilitating activities. One significant step is their continued support of The Children with Special Health Care Needs Advisory Committee (CSHCNAC). CSHCNAC, with its consumer members, is integrally and proactively involved in all aspects of program planning and implementation**. //2004//**

There have been several new initiatives that have expanded CSHCN program's capacity and scope. The "On the Right Track" grant from the CDC-P was responsible for establishment of the Texas Department of Health's (TDH) Virtual Office on Health and Disability. This is a unique cross programmatic effort to raise awareness of disability-related issues among all staff at the Department, which can ultimately impact the provision of services that model the values and philosophy of Title V. The CSHCN program's wellness center services contract initiative is another successful model that reflects inclusive and family centered service provision. The focus of these service contracts is the entire family of the CSHCN and the provision of inclusive health and wellness activities, including nutrition, recreation, health education, etc.

TDH regional staff across the state provides extensive case management services for CSHCN and their families. This staff is trained in the provision of family-centered care.

The CSHCN program may provide family support services as part of the program's health care benefits package. Family support services are family-centered and family-directed and assistance in accessing these services is provided through the TDH regional Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The case management available throughout the state is an open door to CSHCN and their families for information and referral to appropriate local resources. This role is strengthened by the Program's new rules, which stipulate that case management services may be offered to CSHCN and their families who are not applying or eligible for CSHCN.

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/2004/ Due to space limitations of the online application a discussion on capacity in genetics, women's health, and children's health was not included. This discussion will be available during the August review. **//2004//**

/2004/ Culturally Competent Care

TDH, because of the vast diversity of the state's population, works to deliver all services in a culturally competent manner. Current activities in women's health include an expectation that all staff have a working knowledge of cultural competence and the ability to conduct their work in a manner that shows consideration for racial and ethnic differences and for clients with physical, emotional and mental disabilities. People First language is used and all materials are made available in English and Spanish, and often other languages. Title V works to ensure cultural competence from its contractors through contract assurances, training and quality assurance monitoring. Title V program staff also has access to translation services in the TDH Office of Communications.

Most educational materials for children and women are published or made available in at least English and Spanish, and frequently in other languages based on need and demand. For example, the Genetics and Case Management program provides most of its materials in English and Spanish, and in collaboration with the WIC Program, Newborn Screening staff are provided access to telephone translation services to assist patients speaking languages other than English or Spanish.

Most of the programs in the Child Wellness area focus on prevention and early intervention and promote child health and safety through education rather than through providing direct services. For those programs that do provide direct services to children and their families, the majority of services are provided through contractors. All contractors are contractually required to ensure that services are provided in a culturally competent manner. Programs have already, or are in the process, of incorporating questions and assessments about cultural competence in their respective monitoring tools. Areas addressed cover such issues as requiring written policies and procedures to address the needs of clients with limited English proficiency, written non-discrimination policies and procedures as well as same established for compliance with non-discrimination provision of ADA 504 and the appropriateness of materials (i.e., curriculum) for specific populations of clients served. The activity, school based health centers, supplies a self-evaluation checklist for compliance with ADA/Section 504 policies and procedures. All parent educational materials are translated into Spanish and reviewed for cultural accuracy and relevance by TDH's Office of Communications. **//2004//**

TDH, through efforts led by Lesa Walker, M.D., head of the Systems Development Section within the CSHCN Division and Acting Title V CSHCN Director, was awarded a grant from the National Center on Cultural Competency. The Texas CSHCN Program is one of several states participating in the national center's effort to survey cultural competency. In February 2000, staff from the National Center on Cultural Competency visited TDH and conducted an initial training and technical assistance visit. They held a focus group for

consumers/parents of CSHCN as well. They provided the CSHCN Division with copies of a cultural competency survey tool to be used to gather information from several partner agencies and organizations. In June 2000, the CSHCN Division returned the completed surveys to the national center. The survey results were analyzed and a report was provided to the CSHCN Division in 02.

/2004/ The CSHCN Division proactively works to ensure cultural competence including operating a statewide toll-free hotline which individuals can call for information and referral. Bilingual employees staff this phone line. In addition, case management and eligibility staff is also bilingual. The Program's written communications with its clientele are always done in both English and in Spanish, and the Program also has many educational materials available in Spanish.

Another avenue of addressing cultural competence is through the Children with Special Needs Advisory Committee, which has both parent and professional representatives from diverse cultures and from different geographical areas of the state.

To ensure further that the programs services are provided in a culturally competent manner, a survey of CSHCN client and family stakeholders was conducted during the spring of 02 to obtain information about CSHCN client/family stakeholders' opinions and use of program services. Respondents' preferred languages for the interview were documented as English (563 or 61.2%), Spanish (350 or 38.0%), Vietnamese (4 or 0.4%), Urdu (2 or 0.2%), and Arabic (1 or 0.1%). Researchers concluded that the size of the convenience sample coupled with the diversity of respondents' home locations ultimately functioned as a guarantee that the survey reached an ethnically and geographically diverse population. ***//2004//***

/2004/ Findings of this survey are described in the needs assessment update *(see Appendix A).* ***//2004//***

State Statutes

TDH has provided health services for women and children since 1918 and services to CSHCN since 1933. An overview of the State Statutes that directly relate to Title V MCH and CSHCN programs are listed below.

Maternal and Infant Health Improvement Act (MIHIA).

In 1985, the Texas Legislature passed MIHIA, which enabled TDH to establish a model health care program offering a comprehensive array of perinatal services to low-income, high-risk, pregnant women and infants who were not eligible for Medicaid. In 1995, the Texas Legislature passed Senate Bill 1229 to amend MIHIA. This legislation supported health improvements for women and infants by

promoting health education, providing assurance of reasonable access to safe and appropriate perinatal services, and improving the quality of perinatal care by encouraging optimal use of health care resources. TDH has passed rules to establish minimum standards and objectives to implement and monitor a statewide network of voluntary perinatal health care systems at a regional level. TDH will further develop policies for health promotion and education, risk assessment, access to care, and perinatal system structure including the transfer and transportation of pregnant women and infants. Finally, TDH will develop and maintain a perinatal reporting and analysis system to monitor and evaluate perinatal patient care within each region. TDH will provide support to the Perinatal Resource Coordinating group in each of the public health regions and promote coordination and cooperation within Texas and among neighboring states for perinatal care.

The following are laws passed by The 77th Texas Legislature that relate to the Maternal and infant Health Improvement:

HB 1758, which requires gender equity in access to and funds for services, including teen pregnancy;

/2004/ This bill, dealing with the issues facing incarcerated women, was originally assigned to TDH for implementation, but has since been more appropriately assigned to HHSC and the Texas Youth Commission for implementation. **//2004//**

HB 2989, which creates a project to screen school children for acanthosis nigricans in Texas Mexico border counties;

SB 19 requires the TDH to coordinate with the Texas Education Agency in scheduling training for schools to provide daily physical activities to children below the 7th grade;

/2004/ Title V, over the last two years, has supported training at the regional Education Service Centers through the Texas School Health Network. The Texas Education Agency (TEA) has spent the last two years determining criteria for eligible programs that local schools can use and two programs have been approved so far, CATCH and the Great Body Shop. TDH also assisted TEA with the language for SB 1357 during the 78th Legislative Session. SB 1357 builds upon the good work started by SB 19 passed during the 77th Legislative Session. **//2004//**

SB 52 requires licensed childcare facilities to post signs describing SIDS, shaken baby syndrome, and childhood diabetes and methods for prevention;

SB 55 creates a statewide education program to prevent infant mortality;

/2004/ The Shaken Baby Alliance (SBA) was awarded the funding to implement SB 55. SBA staff worked in conjunction with TDH staff and other stakeholders to develop an Infant Mortality Prevention Education Program (IMPEP) that includes a day-long train-the-trainer session and an extensive curriculum filled with additional resources. Training was offered in each of the 11 public health regions in FY 03. Training was conducted by a team that included two TDH Title V staff. Once trained, participants are equipped to utilize the training materials and the curriculum to develop training for their target audiences. SBA has received very limited funding to continue the program for an additional year. TDH staff is expected to continue to assist. **//2004//**

SB 532 provides Medicaid coverage for treatment of breast and cervical cancer for women and diagnosed through the federal Breast and Cervical Cancer Control Program (uninsured women up to 200% FPL).

/2004/ TDH worked collaboratively with HHSC and the Department of Human Services to successfully implement Senate Bill 532, the Breast and Cervical Cancer Treatment Act. As of July 03, approximately 300 women diagnosed with breast or cervical cancer by the Breast and Cervical Cancer Control Program receive full Medicaid benefits while in treatment for their cancer diagnosis. **//2004//**

Children With Special Health Care Needs Services Program Act.

In 1999, the 76th Texas Legislature passed Senate Bill 374 that amended the long-standing Chronically Ill and Disabled Children's Services Program Act. The program changed its name to Children with Special Health Care Needs Services Program effective September 1, 1999. By July 1, 2001, the amended Act requires the program to change its eligibility requirements and scope of services. Currently, the new Children with Special Health Care Needs (CSHCN) Program was to cover additional children who were otherwise uninsured or under-insured. The redesigned program was also to provide family support services not covered by Medicaid, CHIP or traditional insurance programs. The legislation also mandated removing the asset test from the financial eligibility criteria while retaining the medical spenddown provision. A waiting list has been established since service demands exceed the program's budget.

The following are laws passed by The 77th Texas Legislature that relate to the Children With Special Health Care Needs Services Program Act:

- HB 342 (non-Medicaid) and SB 616 (Medicaid) create a children's asthma management pilot to study preventative care versus traditional care

- HB 456 allows reimbursement of certain home health care services to trained persons other than nurses for persons with disabilities in programs using vouchers for certain services
- HB 1308 creates an Office of Early Childhood Coordination and Advisory Committee to conduct strategic planning for coordinating services to children
- HB 1478 continues work of Children's Long Term Care and Health Programs to assist state agencies in developing, implementing, and administering family support policies and related long term care and health programs for children; changes name to Children's Policy Council; involves staff from the TDH CSHCN program.

/2004/ A workgroup tasked with implementation of this piece of legislation produced a report, “And How are the Children? Recommendations for Improving the Well-Being of Children with Disabilities in Texas, “ which analyzes the system of long-term care services and supports for children with disabilities in Texas, identifies system areas needing change and proposes various methods for improving the system. Recommendations included:

- Children with disabilities age 12 and under should not be admitted to any institution, as defined by Senate Bill 368, 77th Texas Legislature.
- Remove the responsibility for permanency planning from the facility where the child resides in order to eliminate the conflict of in interest created when the facility that receives funding for having the child occupy a bed is also responsible for seeking opportunities for family-based options.
- Continue and expand the existing family-based alternatives project.
- Prioritize children who are in institutions. Children under age 18 residing in institutions as defined by Senate Bill 368 should be prioritized for funding that supports children moving into families in the community. This may be accomplished by providing waiver slots for all requesting transition to families, or by allocating 50% of appropriated slots.
- Expand the Rider 37 concept to allow funding to follow the child to the community for children residing in any LTC facilities as defined by Senate Bill 368.
- Fund agency permanency planning efforts.
- Fully fund DHS appropriations request to continue permanency planning efforts in nursing homes;
- Fully fund HHSC's appropriations request to continue funding permanency planning training and monitoring;
- Fully fund MHMR's appropriations request to ensure permanency planning in ICF/MRs and state schools **//2004//**

SB 368 strengthens permanency planning for children with special health care needs residing in state institutions; requires that a state agency notified of

placement of a child in an institution place the child on a waiting list for Medicaid 1915(c) waiver services within three days of notification.

/2004/ Senate Bill 368, whose implementation is coordinated by HHSC, established a framework to begin the development and implementation of family-based alternatives for children in institutions "under which a child who cannot reside with the child's birth family may receive necessary services in a family-based alternative instead of an institution." HHSC worked with agency staff from Texas Department of Mental Health and Mental Retardation (TDHMHMR), the Texas Department of Human Services (TDHS) and the Texas Department of Protective and Regulatory Services (TDPRS) to begin establishing this system in an area with high numbers of children who reside in institutions. A twelve county area encompassing and surrounding San Antonio, Austin, and Temple was identified as the initial target area to begin development of the system. TDHS, TDMHMR, and TDPRS provided initial state funding, with federal Medicaid funds as match. The Governor issued Executive Order RP 13 to HHSC to move forward with the pilot. HHSC issued a Request for Proposal, which was awarded in May to EveryChild Inc.

The model requires interlocking efforts in three domains: child, birth family, and support families. The project uses two Family Support Coordinators who are responsible for comprehensive assessments of children and for working with birth families or guardians (CPS in some cases). The project also utilizes two Recruitment Coordinators who are responsible for finding potential alternate families and arranging for their training and preparation. In the design of the project, EveryChild, Inc. is not a direct service provider, but rather its efforts are intended to supplement the existing system and bring together various elements to create new options. Through partnerships with direct services agencies, children and potential families will be connected to ongoing support.

The methodology for implementing this initiative has been to proceed carefully in order to develop positive relationships with birth families and facilities, and to carefully prepare potential support families and children. The Family-Based Alternatives Initiative is in the preliminary stage with implementation focusing on collaboration and training with partners, recruiting support families and establishing communication and relationships with birth families. Since the award of this contract in May of02, EveryChild has established good community relationships with partners, community centers, providers and HHS agencies, is screening, assessing and developing significant numbers of support families and has had significant positive response from birth families interested in family based alternatives for their child.

The project has accomplished the following in the months since the contract was awarded:

- Contacts have been made with over 750 individuals to explain the project and the system of family-based alternatives it seeks to create.
- Relationships have been established with 3 nursing homes, 1 TDPRS institution, and 1 ICFMR institution serving a combined total of 161 children.
- EveryChild, Inc., in coordination with responsible agencies (TDHS, TDPRS, TDMHMR), has identified 291 children in facilities in the twelve target counties, obtained initial information on permanency plans and birth families, and collaborated on prioritization of children.
- Comprehensive assessments are in process for 18 children.
- Relationships have been established with an initial group of 5 birth families who have expressed interest and 13 CPS guardians who are actively exploring possible family-based alternatives.
- Transition planning has been authorized by 3 families and plans for movement to family-base alternatives are being finalized.
- Recruitment efforts have resulted in 112 inquiries from potential families who are interested in caring for a child with disabilities.
- Home visits and initial assessment have occurred for 12 families and are scheduled for an additional 9 interested families.

Experience with similar systems in other states has shown that the process of recruiting, screening, assessing, training, and matching a new support family with a child and their birth family takes twelve to eighteen months. To date, seven children have been placed in family situations and the reception from birth families and the response from potential support families (over 400 calls have been received from families interested in taking a child) has met or exceeded the pilot's expectations. **//2004//**

SB 831 creates a Medicaid buy-in pilot for working persons with disabilities between ages 16 and 64.

/2004/ This program is administered by the Texas Department of Human Services. Currently, federal funds are newly available for states to create a Ticket to Work Buy-In Program that allows disabled individuals to work, but not lose their Medicaid benefits. S.B. 831 (77th Legislature) creates three pilot programs, one rural, one urban, and one in the Texas-Mexico border region, to take advantage of these funds. The Department of Human Services is directed to report the effectiveness of the pilot programs and make recommendations about statewide expansion. **//2004//**

Rider 28 to the appropriations bill, SB 1, allows TDH to reimburse consumer representatives on the Children with Special Health Care Needs Advisory Committee.

The CSHCN Division staff are making progress toward the fulfillment of each of the laws listed above.

Newborn Screening Program.

In 1965, the Texas Legislature passed legislation establishing the Newborn Screening Program and gave TDH the authority to implement the program. All Texas newborns are screened for phenylketonuria (PKU), galactosemia, sickling hemoglobinopathies (including sickle cell disease), congenital adrenal hyperplasia, and hypothyroidism.

The law requires that all newborns who have been screened and found to be presumptively positive for heritable diseases receive follow-up. Children at or below 200% FPL may receive services through the Children With Special Health Care Needs Services Program, including medical care, case management, and necessary dietary supplements. Individuals with PKU may receive dietary supplements at no cost or reduced cost, based on family income. In 1989, the 71st Legislature amended Chapter 31 of the Insurance Code to provide for health insurance coverage for PKU formula, similar to that for prescription drugs. Title V is providing funds to pilot the use of medical foods in managing PKU.

Special Senses and Communications Disorders Act.

In 1989, the 71st Legislature passed the Special Senses and Communications Disorders Act for the purpose of establishing a program for early detection of children from birth to 20 years of age who have special senses and communications disorders and need remedial vision, hearing, speech and language services. Early detection and remediation of those disorders provide individuals with the opportunity to achieve appropriate academic and social status through adequate health and education intervention.

Another requirement of this Act is the registration of audiometric equipment with TDH. The Bureau of Children's Health Audiometric Laboratory provides support for the Vision and Hearing Screening Program by annually calibrating and repairing the audiometers owned by TDH and by loaning this equipment to day care centers, private schools, small school districts, and home school groups for hearing screening to comply with state requirements.

/2004/ The program continues to test, register and loan out equipment although funding issues have eliminated the ability of the program to visit doctors' offices to calibrate their equipment on site. **//2004//**

House Bill 714 of the 76th Legislature requires birthing facilities to offer hearing screening for newborns. TDH is required to certify screening programs at all birthing facilities and to provide data tracking software and technical assistance to all Medicaid facilities. The legislation further requires TDH to ensure access to

appropriate Early Childhood Intervention (ECI) services and requires inclusion of newborn hearing screening services under Medicaid and any health benefit plan covering children. Intervention services for children under 200% of poverty not eligible for Medicaid or CHIP will be provided through the Title V Program for Amplification of Children of Texas (PACT).

/2004/ One-hundred ninety-four (194) hospital programs have been certified for meeting program criteria. Ninety-seven (97) or 50% have exceeded minimum performance levels and achieved "distinguished certification" by ensuring that at least 97% of newborns are screened during the birth admission; and 95% of newborns pass the birth admission screen. Though Ninety-two (92) birthing facilities are exempt from the state reporting law, 22 are certified to report data; 40 others refer infants to larger hospitals or outpatient facilities for screening; and 30 have certification pending. **//2004//**

Birth Defects Monitoring Program Act.

In 1993, the 73rd Legislature gave TDH authority to establish a Birth Defects Surveillance and Registry program for the purpose of identifying and investigating certain birth defects in children and for maintaining a central registry of birth defects cases. The program is required to provide information to identify risk factors and causes of birth defects, conduct interview studies about the causes of birth defects, support the development of strategies to prevent birth defects, and maintain birth defects data in a central registry. Children with birth defects receive case management for assistance in applying for financial or medical assistance available through existing state and federal programs, including the CSHCN Program and Medicaid.

Abnormal Spinal Curvature in Children Act.

Under Chapter 37, the TDH Spinal Screening Program facilitates the detection of abnormal spinal curvature in children through spinal screening in Texas schools. The program provides training and certification to spinal screener instructors and spinal screeners; approves spinal screening training programs, establishes standard spinal screening tests and referral criteria, monitors the quality of spinal screening activities, issues reporting forms, provides educational materials to assist spinal screening activities, and maintains records of approved instructors and screeners.

Midwifery Act.

TDH is responsible for administering the Midwifery Program to assure annual documentation of direct entry midwives (as distinguished from certified nurse midwives) and interacts with the Midwifery Board and its committees. The Midwifery Program maintains a roster of annually documented midwives,

publishes a basic midwifery information manual, compiles midwifery statistics, and processes complaints against midwives. The Midwifery Program is advised by the Midwifery Board, which is appointed by the Board of Health. The Midwifery Board investigates and resolves complaints against midwives, approves rules and standards of practice for midwives, and advises the Board of Health on other midwifery issues. The Midwifery Board also approves basic midwifery courses, certification exams and continuing education courses.

Oral Health Improvement Act.

TDH is responsible for establishing the Oral Health Improvement Services Program to provide comprehensive oral health services to eligible individuals. Oral health services include direct preventive and treatment services, fluoridation of community water supplies, oral health education and promotion activities, sealant programs, continuing health education programs for providers, public health education in preschools, schools and adult education programs, outreach activities to promote awareness of oral health service programs, and activities to address provider availability across the state. The program conducts field research and prepares reports relating to the need for and availability of oral health services. TDH is not required to provide services unless funds for oral health services are appropriated to TDH.

In FY 2000, TDH received significant reductions to the Public Health Services Block Grant and the Fluoridation Program funding was eliminated. The Texas Title V Program has provided funding to the Fluoridation Program to continue funding new fluoridation systems and to upgrade existing system in need of repair. In FY 03, the Fluoridation Program will be again funded through the Public Health Services Block Grant.

Laws affecting the Oral Health Improvement Services Program passed by the 77th Texas Legislature are as follows:

- HB 2614 establishes a pilot to provide oral health services to indigent children in Texas-Mexico border counties.
- HB 3507 requires dentists participating in the Medicaid program to document the dental necessity for a stainless steel crown before the crown is applied; requires TDH to strengthen the method of determining dental necessity for hospitalization and use of general anesthesia for children in the Medicaid program; reduces hospitalization fees, eliminates nutritional consultation fees, and limits behavioral management fees; creates a teledentistry pilot to provide dental services to Medicaid eligible children in one public school in the state; and allows delegation of certain services by a dentist to a dental hygienist providing services in long term care facilities or school based health centers.

Injury Prevention and Control Act.

This legislation establishes a list of reportable injuries, which include spinal cord and submersion injuries and elevated blood lead levels. The Board of Health has the authority to establish rules to designate blood lead concentrations and ages of children that must be reported. TDH has the authority to seek, receive, and spend funds on identifying, reporting, and preventing injuries; to conduct epidemiological studies; to evaluate trends; to make inspections and investigations; and to establish a childhood lead registry.

Child Passenger Safety Seat Systems Act.

This legislation permits TDH to establish a program to distribute child passenger safety seats to indigent persons and allows the Board of Health to adopt program eligibility rules.

/2004/ TDH continues to meet the mandate of this act and in fact TDH has become the sole distribution point for the state. **//2004//**

The Senate Bill 113 of the 77th Texas Legislature sets new, more stringent requirements for securing children in car safety seats.

Sudden Infant Death Syndrome (SIDS) Act.

New legislation passed during the 76th session requires that the death of a child 12 months old or younger be reported to the Justice of the Peace, medical examiner, or other proper official if the child dies suddenly or is found dead and the cause of death is unknown. The official is required to inform the child's parent/guardian that an autopsy will be performed. The law directs TDH to reimburse a county up to $500.00 per autopsy if the cause of death is SIDS. Previous law requires TDH to develop a model program to provide information and follow-up consultation about SIDS and to promote public awareness and understanding of SIDS.

C. ORGANIZATIONAL STRUCTURE

TDH is the state agency responsible for administration of the Title V Program and is 1 of 13 state health and human services agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). House Bill 2641 of the 76th Texas Legislature enhanced HHSC's operational responsibility for managing and directing the health and human service agencies through greater supervision of each agency commissioner. As a result, the HHSC Commissioner is authorized to employ the Commissioner of Health with the Board of Health's concurrence and Governor's approval and to supervise and direct the activities of the Commissioner of Health. Further, the Board of Health is required to enter into a Memorandum of Understanding with the HHSC Commissioner. HHSC has

responsibility for coordinating development and submission of joint agency strategic plans and a consolidated budget. HHSC is involved in policy development for all TDH programs and, as such, reviews all proposed rules of the health and human service agencies. HHSC, as the State Medicaid Agency and CHIP agency, is the official policy making body for the portions of those programs administered by TDH. The increased authority and responsibility of HHSC has been instrumental in increasing coordination for planning and implementation and has helped reduce duplication and maximize resources across the heath and human service agencies.

/2004/The existing organizational chart for HHSC is available at http://www.hhsc.state.tx.us/about_hhsc/hhsc_org.html. **//2004//**

/2004/ How health and human services will be organizationally and administratively aligned was dramatically changed during the 78th Legislative Session. By mandate of HB 2292, the Governor and Legislature directed Texas health and human service agencies to consolidate organizational structures and functions, eliminate duplicative administrative systems, and streamline process and procedures that provide the delivery of health and human services to Texans. Currently, health and human services are provided to millions of Texans through an array of services with a sometimes complex and confusing framework of policy-making, management and administration, and delivery systems. At present, 12 separate agencies, expend an estimated $19.5 billion per year to administer over 200 programs, employ about 50,000 state workers, and operate from over 1000 different locates across Texas. The policy changes in this bill are designed to contain rising health care costs while ensuring that the most needy Texans continue to receive essential services. The major provisions of HB 2292 are:

- Agency Consolidation – Operations of the 12 existing health and human services agencies will be re-aligned by consolidating functions in 4 agencies with oversight by HHSC. Those agencies are Department of State Health Services, Department of Aging and Disability Services, Department of Assertive and Rehabilitative Service and the Department of Family and Protective Services. Administrative and eligibility functions will be consolidated into HHSC. TANF policy responsibility transfers to HHSC and all advisory committees (unless mandated by federal law and/or executive commissioner mandate) are abolished. Most TDH programs, including most Title V programs will become part of the Department of Health Services.
- Oversight and Accountability – A governor appointee serves as HHSC executive commissioner. A commissioner appointed by the executive commissioner and approved by the Governor will supervise each of the other 4 entities. A council of 9 gubernatorial appointees will be created for each agency to advise the agency commissioner on agency policies and programs. Commissioners of the individual agencies will

develop rules for their respective agencies, with final authority to adopt rules for each HHSC agency.

- Transition to Consolidated System – HHSC is responsible for developing a transition plan by December 03 to reflect the initial vision and timelines for the consolidation. Full consolidation is anticipated to take between 4 to 6 years. Some of the consolidating and streamlining efforts have already begun, such as the consolidation of all human resource functions from multiple agencies into HHSC as well as the migration to a common automated system for accounting and administrative transactions.
- Transition Oversight and Public Input – A legislative oversight committee will be created to facilitate the consolidation with anticipated minimal disruption of services and to provide ongoing guidance. The committee will solicit public input in the development of the transition plan and will hold a public hearing(s) on the plan no later than November 1, 2003. The final plan is due to the Governor and Legislative Budget Board no later than December 1, 2003. **//2004//**

TDH Organization.

There have been major changes in key agency personnel and organizational structure since the last submission of the Block Grant Application:

/2004/ The current organizational structure for TDH is illustrated at http://www.tdh.state.tx.us/orgchart.htm **//2004//**

On November 5, 2001, Eduardo Sanchez, M.D., began his tenure as Texas Commissioner of Health. Prior to his appointment, Dr. Sanchez was an Austin family practice physician and health authority for the Austin-Travis County Health and Human Services Department. Dr. Sanchez replaces William R. Archer III, M.D., who resigned in October 2000. Texas Department of Health (TDH) Executive Deputy Commissioner Charles Bell, M.D., performed the duties of the commissioner of health during the interim.

Gary R. Bego was named Chief Operating Officer for TDH in Sept 01. Mr. Bego has worked for the HHSC as an Associate Commissioner since 1995. TDH is 1 of 13 state health and human services agencies under the umbrella of HHSC. He has held executive positions in fiscal and administration for Health Care Financing at TDH and the Department of Human Services. Following these appointments and with the TDH Board of Health approval, TDH reorganized its programs into three Associateships: Associateship for Disease Control and Prevention, Associateship for Family Health, and Associateship for Consumer Health Protection. All 3 associateships report to the Deputyship for Programs under the leadership of the Deputy Commissioner for programs, Ms. Debra Stabeno. Ms. Stabeno reports to the Executive Deputy Commissioner, Dr. Charles Bell Within the Deputyship for Programs, the Title V is located in the

Associateship for Family Health. Ms. Debra Wanser became the Associate Commissioner for Family Health, effective January 02. Ms. Wanser served as State Title V Director for about three years. Dr. Fouad Berrahou was selected as the State Title V Director effective July, 02. The Associateship is comprised of 5 bureaus and 1 division under the Associate Commissioner. The bureaus are: Bureaus of Support Services, Nutrition Services, Children's Health, Women's Health, Kidney Health Care. And the Title V Systems and Processes Development Division. The Associateship has administrative responsibility for most of the TDH programs and funding streams dedicated to women and children's health including Title V MCH and CSHCN, Medicaid - EPSDT medical and dental, WIC, Family Planning - Titles X, XX, and XIX, Breast and Cervical Cancer Control Program, and the Medicaid Medical Transportation Program. As such, the Associateship is in a position to coordinate and collaborate across programs effectively.

The Support Bureau includes five divisions that support all of the Associateship programs and activities: Financial Management, Research & Public Health Assessment, Quality Assurance and Monitoring, Automation Planning, and the Health Communications Division.

The Bureau of Nutrition Services includes the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Farmer's Market Program; Public Health Nutrition Program; and Electronic Benefits Transfer. Mr. Mike Montgomery is the Bureau Chief and State WIC Director.

The Bureau of Children's Health (BCH) is made up of 5 divisions that include the Children with Special Health Care Needs, Child Wellness; Genetics and Case Management; Oral Health Services, Texas Health Steps Division (EPSDT) and Medical Transportation Program; and Information and Referral Line for Maternal and Child Health programs. Ms. Jann Melton-Kissel is Chief of the BCH.

The Bureau of Women's Health includes the Division of Family Planning (Titles V, X, XIX, and XX), Women's Health Laboratory, Division of Breast and Cervical Cancer Control Program (moved from Bureau of Chronic Disease), Maternity and Perinatal Health Office of Special Projects which includes the Texas Breastfeeding Initiative, Domestic Violence Prevention Program, Male Involvement Project, Osteoporosis Program, and Office of Women's Health. Ms. Margaret Mendez was named Bureau Chief in December 1999.

The Title V Systems and Process Development Division includes the general administration of the State Title V Program, Primary Health Care (PHC) Contracts Program, and the State County Indigent Health Care Program. As part of the last realignment, the PHC Program and the County Indigent Health Care Program moved under the Title V Division Director. This offers opportunities to streamline both Title V and PHC, along with Titles X and XX contractual policies and procedures. The State Title V Director has the responsibilities of managing

the Title V Systems and Processes Development Division and reports to the Associate Commissioner for Family Health.

/2004/ Leadership and organizational reporting transition at TDH continued during FY 03. In March 03, Dr. Nicholas Curry was appointed to serve as Acting Executive Deputy Commissioner, replacing Dr. Charles Bell who took a position with HHSC. Previously, Dr. Curry served as the Director of TDH Public Health Region 1. His duties included coordination and oversight of the delivery of comprehensive public health services in 41 counties, developing and supporting community health partnerships, and managing regional resources.

Prior to coming to TDH Dr. Curry served as the principal for CCA Health Systems providing consultation on health systems management, health policy, health risk communications, and health organizations management. He has also served as the President and CEO of the Community Health Foundation of Tarrant County; Inc. Dr. Curry was the Director of Public Health for Tarrant County Health Department and Fort Worth Health Department after serving as the Chief for Clinical Services for the Houston City Health Department.

Dr. Curry holds a Master of Science degree from the University of Georgia and an M.P.H. from the University of Alabama. He received his medical degree from Baylor College of Medicine. He is Board Certified in Public Health and General Preventive Medicine, and in Quality Assurance and Utilization Review. **//2004//**

/2004/ Ben Delgado, formerly Deputy Community for Administration became the Acting Chief Operating Officer, and Gary Bego, formerly Chief Operating Officer, became Acting Deputy Commissioner. Mr. Delgado has a Bachelor's in Business Administration and English from the University of Texas-Austin. He has 24 years experience in state government in executive management, and in administrative and legislative areas. **//2004//**

/2004/Sam Cooper was selected as CSHCN Division Director in April 03 and brings a range of experience in social work, quality assurance and public health to this capacity. Dr. Lesa Walker served as Acting Director until Mr. Cooper's selection and continues to serve as the CSHCN Title V Director. The CSHCN Division director is responsible for the administrative functions of the Division and provides management, direction and guidance in strategic operations. The Medical Director provides medical and public health expertise and leadership required to achieve the goals of the Division**. //2004//**

D. OTHER MCH CAPACITY

Appendix C provides the number and types of full-time equivalent personnel funded by the federal-state Title V program. This information is based on the Title V administrative allocation budget for FY 2003 as of June 2003. Table 1 of the attachment shows a total of 244 positions funded in the Associateship for

Family Health (TDH Central Office in Austin) with federal Title V and state general revenue funding. Table 2, Appendix C shows a total of 340 positions funded with federal Title V and state general revenue funding in TDH's 11 public health regional offices.

Within the Title V program, each staff member uses planning to some extent to influence the course of his or her daily activities and responsibilities. However, because managers have the greatest amount of contact with the environment and thus are in best position to know what their programs will face in the future, they make current program operations and policy decisions in the light of their future effects. Managers include bureau chiefs, MCH and CSHCN Title V directors, and program division directors. In some instances, directors may delegate the decision-making function to selected program specialists who, on a routine basis, play the role of catalysts in or facilitators of the planning process. It is important to note that some TDH program specialist job descriptions are similar to those of conventional planners. On the other hand, researchers and statisticians provide data and information, which are essential ingredients in the planning process and decision-making. Researchers appraise the performance of interventions and programs, and then propose the necessary adjustments to bring the program to the desired objectives. Statisticians collect primary and secondary data from multiple sources and critically analyze data to illustrate meaningful associations.

Appendix D contains summaries of the qualifications of senior level employees (item 3), including Executive Deputy Commissioner, Associate Commissioner for Family Health, Bureau Chiefs for Children's Health, Women's Health, Nutrition Services, and Support Services, and both Title V MCH and CSHCN Directors.

Currently, 11 parents of CSHCN and advocates serve on the TDH CSHCN Advisory Committee. Their role is to advise the Board of Health as well as the Bureau of Children's Health on policies, programs, and systems development for CSHCN and their families. Additionally, the State Title V CSHCN posted a program specialist position to hire a parent of a child with special health care needs to consult in developing and implementing a plan to enhance parent participation in program and policy activities. A top candidate has been selected and offered the job. The new staff member has an extensive knowledge of issues related to CSHCN and their families, and is a close relative to a child with special health care needs. She joined the program in July 2000.

/2004/ The parent consultant participated in reviewing the program’s rules and requests for proposals for new initiatives and the Title V Block Grant Application, but due to budgetary constraints, is no longer funded by the program. Consumer members of the CSHCNAC continue to provide support in this area as well. **//2004//**

In addition to the CSHCN Advisory Committee, there are six advisory committees that support Title V and related programs within the Associateship. There are a total of 78 members for all MCH and CSHCN advisory committees; of those, 30 members are consumers and/or advocates. A summary of the CSHCN and other MCH-related advisory committees is listed in Appendix E, Table 4.

/2004/ HB 2292 of the 78th Legislative Session limits the role of advisory groups in health and human service agencies to only those mandated by federal law (e.g., Family Planning Advisory Committee) or those determined essential by the HHSC commissioner. TDH values stakeholder input and is currently working to identify ways to keep or reorganize these groups to ensure opportunities for stakeholder input. There are now 38 members who are consumer and/or advocates. **//2004//**

The organizational relationship of the Texas Department of Health to the other health and human services has been described in Organizational Structure. Title V staff within the Associateship for Family Health have ongoing program and project-specific relationships with all the agencies under the umbrella of the Texas Health and Human Service Commission, as well as with other agencies not under the HSSC, such as the Texas Education Agency.

The Title V program has longstanding contractual and collaborative relationships with local health departments (LHDs), federally qualified health centers (FQHCs), and FQHC look-alikes. LHDs and FQHCs are actively involved in local health planning, including development of coalitions for women and children's services. Title V also maintains ongoing collaborative relationships with university-based education and clinical services programs and with tertiary care facilities. Title V contracts with LHDs, FQHCs, universities, and other community-based providers for MCH and CSHCN direct and enabling services, population-based services, training, assessment and evaluation, and other population-based and infrastructure building activities.

/2004/ The 78th Legislative Session appropriated $10 million for the FY 04-05 biennium, or $5 million per year, to maximize federal resources and increase the provision of health care services to uninsured and medically underserved populations throughout the state. This funding will provide seed money to expand the number of new sites operated by new or existing community health centers. TDH is in the process of creating a Federally Qualified Health Center (FQHC) Incubator Grant Program to position strategically clinics to apply for and receive support as FQHCs.

In addition, the 78th Legislature appropriated $23.4 million for the FY 04-05 biennium, or $11.7 million per year, for the delivery of direct primary health care services. The legislative intent for the Primary Health Care program is to continue the provision of primary health care services through the implementation of a new service delivery model. Under this model, funding

awards will be made through an allocation formula to counties with communities located in medically underserved areas having a high number of uninsured and a disproportionate burden of health disparities. The goal is to implement this program by March 1, 2004.

Both of these programs have been placed under the oversight of the Title V Director. This will provide further opportunities for streamlining and integrating policies and procedures from different programs affecting the MCH population. **//2004//**

University faculty and staff serve on TDH committees, task forces and Title V staff also participate in university and facility-based projects by assisting with development and implementation of grant projects and new programs. All of the above organizations enhance the capacity of the Title V program to deliver direct, enabling and population-based services and to build the public health infrastructure for all women and children in Texas.

E. STATE AGENCY COORDINATION

The organizational relationship of the Texas Department of Health to the other health and human service agencies has been described in the Organizational Structure Section. Title V staff within the Associateship for Family Health have ongoing program and project-specific relationships with all the agencies under the umbrella of the Texas Health and Human Service Commission, as well as with other agencies not under the HSSC, such as the Texas Education Agency.

/2004/ As noted in the organization structure section, HB 2292, 78th Texas Legislature, will have significant impacts in this area. Specifically in the areas of agency consolidation; oversight and accountability; transitions to consolidated systems; and significant oversight by legislators on the transition and extensive public input. Implementation of this mandate should likely improve interagency collaboration. **//2004//**

Healthy Start Projects

Title V Program staff are participating with the Texas Healthy Start Projects in developing a stronger collaboration between Healthy Start and Title V. As we recognize our mutual goal of improving perinatal health outcomes for mothers and children, we identified some activities intended to increase collaboration. Those activities include the following:

Healthy Start Projects and the Title V MCH Program will continue holding quarterly meetings for continued planning and collaboration. These meetings can serve as a forum for related topics and include other invited guests who represent programs/activities related to perinatal health. Some of the programs identified include Texas Health Steps (Title XIX-EPSDT), Children's Health

Insurance Program (Title XXI), Texas Healthy Kids Foundation, HIV/STD Program and WIC.

Title V MCH Program will continue establishing working relationships between the Healthy Start Projects and the TDH Public Health Regional Directors and the MCH Regional Coordinators in each of the Healthy Start Project locations.

Healthy Start Projects will continue participating in planning and developing a "Women's Health Agenda" (a statewide initiative, coordinated by TDH, Bureau of Women's Health).

Healthy Start Projects will continue providing input to the Bureau of Women's Health in planning and implementing the Perinatal Regionalization Rules in FY 2003. The Healthy Start Projects could provide leadership and be key participants at the regional level.

Under the leadership of the Region VI HRSA Office and the Healthy Start Projects,

The Bureau of Women's Health staff is providing support to the San Antonio Healthy Starts project in planning for the FY 2003 conference focusing on postpartum depression.

The Texas Title V Program and the Texas Healthy Start Projects will continue participating in development and implementation of the Region VI 3-year strategic plan.

/2004/ There are several ongoing projects that Texas Title V staff works with in collaboration with the Texas Healthy Start Alliance (THSA). These ongoing activities include assisting in planning for (and attending) the annual DHHS Region VI Healthy Start Conference; planning for and planning to attend the annual Texas Healthy Start education conference; Title V staff participation in the annual Healthy Start grantee meeting; planning of and participation in the quarterly THSA meetings, development of annual letters for support fro the Texas Health Start projects and provision of data to the Texas Health start projects by TDH's Research and Public Health Assessment Division. Currently under consideration for FY 04 joint Title V staff and Healthy Start staff projects are a Title V staff member serving as liaison to the Ft. Worth Health Start (Catholic Charities) infant mortality workgroup. The goal of this group is to work with Healthy Start to implement their community-based approach to infant mortality and other perinatal issues in other parts of Texas. It is also proposed that Healthy Start staff collaboratively work with TDH to implement HB 341, 78th Legislature regarding parenting and postpartum counseling information and perinatal systems in Texas. Another proposed collaboration is for TDH and THSA to produce a parent education conference in January 05. Finally, TDH

staff and Healthy Start stall will be working to identify Healthy Start data needs and develop a plan to provide the data to individual projects. **//2004//**

/2004/Ongoing partnerships with other state agencies and federal agencies and partners play an important role in Title V and TDH meeting the needs of the MCH population. Some of these partnerships are detailed below. **//2004//**

Coordination with Medicaid

The Texas Health Steps (formerly EPSDT) program is operated by TDH and is administered through a Division under the Bureau of Children's Health. Title V and Texas Health Steps program policies and activities are coordinated.

The Texas Department of Human Services (DHS) is responsible for Medicaid eligibility determination. TDH has an interagency contract with DHS to 1) perform oral information and referral on Texas Health Steps, family planning, and immunization services to newly eligible and re-certified Medicaid clients; and 2) provide client eligibility data to TDH to facilitate program outreach and effective utilization of services. Under the contract, TDH is responsible for providing educational materials including videotapes for DHS waiting areas. Both agencies agree to share information and collaborate on issues related to coordination of the Texas Health Steps, family planning, Immunizations, Managed Care, and other Medicaid services. The MOU is reviewed on a yearly basis and any changes are published in the Texas Register.

/2004/ This interagency contract has undergone TDH management, legal and programmatic review and suggested revision and is pending renewal at this time. **//2004//**

TDH also has an MOU with the Texas Education Agency for the School Health and Related Services (SHARS) program. The SHARS program allows school districts to claim Medicaid reimbursement for ten health-related services (occupational therapy, physical therapy, speech/language therapy, medical services, school health and psychological services, assessments, audiology, counseling and special transportation). School districts certify the state share using existing state and local funds to receive the federal share. The MOU outlines individual agency and joint responsibility for program administration including communication with school districts, data collection, training, development of state rules, rate setting, and claims payment.

CSHCN program staff provide leadership in Medicaid medical policy development, in particular that for CSHCN, and the Medically Dependent Children Program (Medicaid Waiver) of the Department of Human Services.

/2004/ CSHCN staff continue collaborative work with Medicaid staff at HHSC to align policies between the two programs whenever possible. During FY 2003

policy work was concentrated on updates and revisions mandated by the elimination of local codes with implementation of the Health Insurance Portability and Accountability Act (HIPAA). CSHCN staff attended bi-monthly Medicaid Medical Policy meetings; monthly Medicaid Pricing Workgroup meetings and many HIPAA related workgroups meetings. **//2004//**

Coordination with Other Federal Programs

The Associateship for Family Health administers both the WIC and Family Planning (Titles V, X, XX, and XIX) Programs. The Title V program coordinates regularly with these programs. TDH also serves as a member of the Texas Planning Council for Developmental Disabilities; the TDH representative to the Council is from the Bureau of Children's Health.

MOU for Coordinated Services to Children and Youth Community Resource Coordination Groups (CRCGs) for Children and Youth.

The 77th Legislature enacted legislation that strengthens and supports the work of the CRCGs of Texas whose main objective is to procure health services for children and adults who fall between the cracks and to coordinate services to children and youth who need services from more than one agency. SB 1468 calls for a joint Memorandum of Understanding between health and human services agencies, related state agencies and state-level partners to promote a statewide system of local-level interagency staffing groups (CRCGs) to coordinate services for persons of any age in need of multi-agency services.

In general, the legislation:

- Updates the previous authorizing CRCG legislation for children and youth,
- Adds the requirement to implement a system for CRCG for adults,
- Includes the requirement to have as a standing representative on each local CRCG, a parent or family member on each CRCG for Children and Youth and/or a consumer or caregiver member on each CRCG serving adults, and
- Requires a legislative report every two years to the Governor of Texas and to participating agency CEOs to report the benefits and barriers of CRCG activities.

The joint Memorandum of Understanding has been developed and signed by all 11 health and human services state agencies and other partners. TDH and Title V support both CRCGs for children and youth and CRCGs for adults. Title V social workers at the regional level are represented on all local CRCGs, and TDH central office staff serve on the State Advisory Committee. The state CRCG Advisory Committee meets regularly and reviews its MOU annually.

/2004/ During FY 2003, the total number of local CRCGs increased to an all time high of 163. This number provides access to and in each of Texas' 254 counties. A state meeting on CRCG was held for all interagency staff and many families whose children had been staffed during the year received free stipends to attend. Areas of training and consultation to the local groups were:

- Development of interagency partnerships and effective networking;
- Improvements in service coordination outside of the CRCG process;
- Increased agency accountability;
- Providing participants with the opportunity to learn about other agencies and services.
- Increased focus upon families and fostering a sense of community.

Additionally, needs were identified for special emphasis for the coming year. These were:

- Funding strategies
- Attendance at local groups
- Training and Technical Assistance
- Public Awareness
- Family involvement and empowerment
- Patterns of referral
- Early Identification and Prevention
- Sustainability
- Mobilization of Community Power Brokers
- CRCG Chair and Staff Roles and Responsibilities
- Redesign of Individual Staffing Teams
- Wraparound Services **//2004//**

Providers Who Refer Pregnant Women and Infants to Title XIX

In FY97, TDH contracted with providers across the state to provide MCH services including maternity, family planning, child health and dental services, and case management services. As part of the Title V eligibility determination process, Title V policy requires all providers to screen applicants for potential Medicaid eligibility. Potentially eligible Medicaid clients are referred to DHS. TDH has a software agreement with DHS to use the DHS Texas Eligibility Screening System (TESS) software to determine potential eligibility for services. All Title V providers are encouraged to use the TESS system or to collect equivalent information using other screening tools approved by TDH.

Coordination with CSHCN-Related Agencies and Family Support Programs

TDH coordinates regularly with the Texas Rehabilitation Commission Disability Determination Unit concerning children who are SSI-eligible.

In addition, families and advocates are active in state policy and systems development as partners with the CSHCN Program and other health and human service agencies and organizations on the Regional Advisory Subcommittees for CSHCN in Medicaid Managed Care. Parents and interested consumer advocates have participated in monthly meetings to address policy and systems issues pertinent to CSHCN as Medicaid Managed Care is implemented in Texas.

Parents, as well as advocates, have been active participants in the redevelopment plan for the CSHCN Program.

Access to Health Care Services

Title V is participating in a workgroup charged with developing recommendations addressing the shortage of health care services. The Workgroup is looking at ways to expand the federally qualified health centers (FQHCs) in the state. Texas has 181 FQHCs in 58 counties. In 2001, these community health centers provided health care to 483,452 Texans and 59.2 percent of those patients were uninsured.

/2004/ Refer to the section titled Other MCH Capacity for an update on activities related to FQHCs. **//2004//**

/2004/ Other collaborations have been detailed in other sections of this narrative and will remain an important focus as we struggle to meet increasing demands. As demands for service significantly increase, enhanced collaborations with other state agencies (including institutions of higher education), federal agencies and private partners will become increasingly important. Collaborations with and benefits of those collaborations with new partners will be a focus of the next five-year needs assessment process. **//2004//**

F. HEALTH SYSTEM CAPACITY INDICATORS

/2004/ Capacity of Texas' health system is a vital component of the infrastructure's ability to promote and protect the health of women, children and CSHCN. Reviewing, and translating that review into action, the FY 2002 Health Systems Capacity Indicators yields important information for Title V. This information will be translated into a cornerstone of the next five-year needs assessment.

As an example, data indicate that there was an improvement from 54.7% in FY 01 to 68.5% in the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN. This improvement is related in part to an enhanced effort in case management.

Several system capacity indicators demonstrated significant increases during this five-year cycle; One in particular is HSCI 04 relative to prenatal visits. From FY

98 to FY 02 this indicator realized a 13.5% increase. Prenatal care is essential not only to the health of the mother but also to that of the child. Continuing increases in this area should impact the future health and well being of both MCH populations.

Some system capacity indicators demonstrate room for improvement in Texas' health care delivery system and will be primary focuses of the next five-year needs assessment. From FY 98 to FY 02 the percent of children hospitalized with asthma increased 7.3% from 32.2% in FY 98 to 39.5% in FY 02. This may speak to the need for more education efforts on preventive visits and the concept of medical home, as often these issues can be resolved prior to hospitalization being necessary.

Based on FY 01 data, a comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the state for low birth weight, infant deaths, prenatal care during the first trimester and prenatal care in general indicate relative consistency among all the populations when viewed in comparisons. This may be in part due to the population-based messages regarding these issues that are seen or heard by more than the intended audience.

The availability of data and the ability to analyze that data is critical to determining the needs of the maternal, child and CSHCN populations in Texas. Texas' public health data infrastructure is in solid and improving shape for this key essential public health function. Data linkages with birth and death records, eligibility files for various programs (i.e., WIC) and newborn screening files are accessible and improving. Texas has a birth defects registry and pregnancy risk assessment monitoring system that yield valuable information for planning and needs assessment activities.

Maintenance of the existing health system capacity and making improvements in that capacity will be critical as we work to provide service to more with often static or decreasing resources. Maintaining and improving this capacity will be an important element of the next five-year needs assessment and the action plans resulting from them. **//2004//**

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2004/ The enhanced accountability provided by the concept of performance measures has been an appropriate and useful tool for Texas' Title V related programs and activities. During an era when budgets are constrained and all resources are tightened coupled with increasing demands for services, the performance measures have helped to frame and focus the efforts of Title V programs and the resources that support them.

During the current needs assessment cycle, a multitude of partners and stakeholders identified an overwhelming number of women, children and CSHCN needs. Using the performance measures as a framework Texas was then able to categorize the needs with a focus on the measures articulated in the seven related outcome measures.

As we approach toward the end of the five-year needs assessment cycle it is appropriate to discuss the overall progress Texas has made toward the 7 health outcome measures. Texas' outcomes have improved in this five year cycle by realizing a decrease in the infant mortality rate in from 5.9 per 1,000 live births in FY 98 to 5.5 in 2002. A moderate increase, but an indication of slow and steady progress in reducing the infant mortality rate. The ratio of black infant mortality to white infant mortality remained relatively stable during this five-year cycle, from 1.8 in FY 98 to 1.7 in FY 02. Enhanced efforts in the area of health disparities are covered in the state overview section and speak to the need to improving Texas' efforts in overcoming these disparities. The neonatal mortality rate per 1,000 births (3.5 in FY 2002) and the postneonatal mortality rates (2.5) and the perinatal mortality rate per 1,000 live births plus fetal deaths remained static over this cycle perhaps indicating the success of the systems designed to influence them. This static outcome also held true also for the ratio of black perinatal mortality rate to the white perinatal mortality rate that improved from 1.1 in FY 00 to 1.0 in FY 02. Mortality is a reflection of the health of pregnant women and the newborn and reflects the pregnancy environment and early newborn care, so we must continue to focus efforts on improving progress toward these measures.

The child death rate per 100,000 children aged 1through 14 moderately improved from 25.8 in FY 98 to 23.1 in FY 02. Activities and resources must continue to be focused on lowering the rate even further.

Texas Title V, in an environment that includes activities outside of Title V's control, has made measurable strides toward improvements in the majority of the outcome measures. Room for improvement continues to exist, and as Texas heads into the next Title V needs assessment cycle, Texas will continue to learn from past efforts and outcomes in framing future priorities over the years. Texas has continued to having proportional dollars spread dedicated towards direct health care, enabling services, population based services and infrastructure building services and will continue to do so in the future to continue on the path of improvement in Texas' MCH and CSHCN populations. **//2004//**

B. STATE PRIORITIES

Title V is concerned about the health status of all Texas residents. As shown in previous submissions of the Needs Assessment Section, one of the methods Title V uses to monitor the state's health is a set of indicators. These health status indicators, which provide measures of health or disease within Title V population, enable us to determine progress made toward achieving state and

national goals established by Healthy People 2010 partnership. These indicators are also used to identify racial and ethnic disparities in health status that indicate unmet public health needs.

Based on the current Needs Assessment process, indicators show improvement in many areas of the health of Texas' population. Others, however, show discouragingly little progress. As part of Texas' effort to improve health status and eliminate health disparities within Title V population the Title V staff include the following priority focus areas, highlighting priority needs for this reporting period. The priority focus areas are organized by the service levels of the pyramid.

Enabling Services

Priority 1. To reduce the number of CSHCN in nursing facilities and other congregate care settings.

Many children with activity limitations or cognitive impairments need ongoing and long-term assistance, yet some do not require institutional care. In 2002, there were about 1,228 Medicaid- eligible CSHCN who were institutionalized in state schools, ICF/MR, and nursing homes. Every CSHCN belongs in a family with a consistent caregiver who takes responsibility for the child's growth, development, and overall well-being. CSHCN still reside in nursing facilities and other congregate care settings. Families with CSHCN need family support services and care options so that CSHCN can remain in families within the community. Currently there is a lack of family support services and family support service providers. Also, there is no method for systematically identifying CSHCN who are at risk of institutionalization and ensuring that they and their families participate in permanency planning. In stakeholders' comments collected at various public hearings, forums, and focus groups, expanding opportunities for community- based services and expanding the availability of respite services for families of CSHCN were the most requested services. The availability of these family support services will address the need to reduce the number of CSHCN in nursing facilities and other congregate care settings.

Population-based Services

Priorities 2 &3. To increase the number of children and adolescents who make healthy lifestyle choices for themselves. To increase the number of children and adolescents who thrive.

Social changes of the last 40 years have led to a dramatic shift in family, neighborhood and community patterns of interaction. Children are left to their own devices while parents are at the workplace, neighbors are absent, and elder citizens are in residential facilities. Recent evidence shows that, more than any other factor health decisions among adolescents are influenced by the degree of

connectedness they feel to family, school, and community. If we are to influence positively the health decisions that our children and youth make, we have to go beyond providing information and teaching skills. We have to ensure that our youth experience a strong sense of connection and caring by the adults directly involved in their lives. We must realign our public health practice to consider and support the quality of life of our children and youth. Achieving this goal represents an opportunity to address the following priority needs: 1) to increase the number of adolescents who make healthy lifestyle choices for themselves and 2) to increase the number of children who thrive. The first priority need index includes A set of indicators, such as tobacco use, alcohol use, teen pregnancy, STDs (chlamydia), motor vehicle deaths, homicide, suicide, and high school dropout. The second priority need index involves the following indicators: immunizations, child abuse, unintentional injury, Medicaid checkups, childhood death 0 - 12 years. Both indexes combine healthy and unhealthy behaviors observed in children and adolescents in Texas. All of these indicators reflect negative behaviors except for the Medicaid checkups and immunizations. In 2002, data revealed that 66.8% of the total population aged 13- 19 years chose healthy behaviors and 66.1% of the total population aged 0-12 years were thriving.

The following are selected indicators included in the above indexes' assessment: infant mortality, low birth weight, teen pregnancy, prenatal care, motor vehicle crashes, suicide death, and homicide.

Priority 4. To reduce disparity in low birth weight rates between Black and White infants. Low birth weight is associated with increased perinatal morbidity and mortality. LBW infants who survive the neonatal period face an increased risk of continuing health problems and long- term disability. These significantly impact Texas families and the health care costs to the state. Birth data in Texas clearly show that specific populations are most affected by LBW, primarily African American families. Relative to the white population, LBW is up to twice as common for African American families.

The consequences are important if this disparity is not addressed. Texas' births will exceed 400,000 by FY 05. Texas must be able to assure adequate resources and planning for the growing number of births throughout the state. While low birth weight and other perinatal health indicators are stabilizing or decreasing statewide in Texas, LBW is not decreasing among African American families. A failure to address the large number of LBW births will mean Texas will continue to need to maintain resources to support a growing number of high-risk low birth weight births throughout the state.

Priority 5. To decrease child and adolescent obesity rates.

Overweight acquired during childhood or adolescence is associated with adverse medical and psycho-social consequences. Childhood obesity may persist into

adulthood with increased risks of some chronic disease later in life. As a result, the rising prevalence of obesity and chronic disease will place more burdens on the health care system, including increased costs of medical care.

Nationally, approximately 13% of elementary school children are overweight. Data on elementary-school children in Texas for 2001 indicate:

- The prevalence of overweight among fourth-grade boys in Texas is 85% higher than estimates for the U.S. as a whole. Among fourth-grade Hispanic boys, it is 139% higher.
- The prevalence of overweight among fourth-grade girls is 63% higher than estimates for the U.S as a whole. Among fourth-grade Hispanic girls, it is 103% higher. Among fourth-grade African-American girls, it is 139% higher. (Source: TDH Innovation Grant)

Nationally, 10.5% of high-school students are overweight. Data on Texas high-school students (grades 9-12) indicate that:

- Approximately 14% are overweight.
- Males (19.4%) are more likely to be overweight than girls (8.7%).
- Minorities are more likely to be overweight than Whites. (Source: Youth Risk Factor Surveillance System, 2001)

Data on low-income, preschool children (1-5 years of age) in WIC indicate that in 2002, 24.1% were overweight. Again, the prevalence of overweight was more pronounced among minorities.

Infrastructure Building Services

Priority 6. To determine Texas baseline children's dental health status.

Dental caries is perhaps the most prevalent disease in the state of Texas. The importance of optimal oral health for children cannot be overemphasized. Early diagnosis and prompt treatment of caries can stop tooth destruction and prevent tooth loss. Based on the 2002 TDH Statewide School Dental Survey of the School Lunch population, 8,092 third to seventh graders of 18,735 surveyed (43.2%) had caries. Title V Oral Health Program staff are committed to reducing this percentage by first determining baseline children's dental health status, which helps not only in assessing the unmet needs but also in designing appropriate future activities to address specific dental needs.

Priority 7. To decrease the prevalence of relationship violence.

One of the TDH Women's Health Division priorities has been to decrease the prevalence of relationship violence through early detection and referral, which may prevent future injuries and decrease medical costs and lost days of work.

Results of a five-year Title X Service Enhancement Project on family violence in Region VI (Texas, Arkansas, Oklahoma, Louisiana, and New Mexico)) indicate that Texas women receiving services from four TDH family planning contractors said they had experienced some form of sexual assault (27.3%) and physical abuse (38%). Currently, a staff person has been hired and activities outlined for FY 2003 such as providing informational materials and web-based training will play a role in addressing this priority needs.

/2004/ An update on the performance assessment for each of the national and state performance measures is presented to this section in *Appendix F* to facilitate further an understanding of the health status of the Texas MCH population**. //2004//**

C. NATIONAL PERFORMANCE MEASURES:

National Performance Measure 01: The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)

a. Last Year's Accomplishments (FY 02):

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures, including posters, manuals, videos, CDs, and on-site workshops. The Newborn Screening (NBS) Laboratory Quality Assurance Officer will provide quarterly unsatisfactory specimen collection reports to the Case Management Program, assist in developing training and educational materials, and participate in on-site workshops.

Update: The NBS Laboratory Quality Assurance Officer worked with the Case Management Program to provide monthly (rather than quarterly) on unsatisfactory specimen collection. The data reflected the number of unsatisfactory specimens and identified providers that were consistently submitting unsuitable specimens to the NBS Laboratory. This information was used to provide training and educational materials to providers. The percentage of total newborn screens identified as unsatisfactory was 1.082 of 360,996 newborn specimens. 176 contacts were made with providers identified as consistently submitting specimens unsuitable for testing. 17,856 educational materials including collection guides, collection posters, CD's, newsletters, urgent message notices and weight conversion charts were distributed. 4 on-site workshops were convened in Austin, McKinney, and two in San Antonio.

Activity 2: Educate parents and health professionals about newborn screening benefits and state requirements by distributing brochures on newborn screening to health care providers; placing information regarding newborn screening on the newborn screening web-site; and making an email address available for any questions regarding newborn screening.

Update: In FY 2002, 122,563 pieces of literature were distributed to health professionals concerning newborn screening benefits and state requirements. These included the newborn screening brochure for parents, new submitter packets, bookmarks and newborn screening posters. The newborn screening web site received 277,545 visits in FY02 over double the number of visits received last year. This increase is attributed to an aggressive marketing approach of the newborn screening web site. During FY 2002, the following information was added to the web site: two issues of a newsletter (the Sickle Cell Rapper), four issues of a newsletter (Newborn Screening News), revised PKU Manuals, and other innovative information. Eight newborn screening presentations were conducted throughout the state. 917 physicians received a targeted mailing on NBS issues with 74 responding to ask for more information. A TDH authored-article on newborn screening was included in the TX. Assoc. of Obstetricians and Gynecologists during FY 2002.

b. Current Activities (FY 03):

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory Quality Assurance Officer will provide quarterly unsatisfactory specimen collection reports to the Case Management Program and assist in developing training and educational materials.

Update: 271,216 initial specimens were received by the TDH laboratory during the first three quarters of FY 2003. Of these, a total of 2,978 or (1.098 percent) were unsatisfactory for testing. 86 technical assistance contacts were made to providers from Sept. 2002-May 2003. About 14,053 educational materials targeted at providers were distributed and included collection guides, collection posters, CDs, newsletters, practitioner guides and weight conversion charts. Thirteen on-site workshops were held. These included Neonatal In-Service Training (Austin), Residency Training at Beaumont Army Medical Center (El Paso), Georgetown School of Nursing, Residency Training-University of North Texas (Denton), Residency Training-Wilford Hall (San Antonio), Residency Training-Texas Tech (Lubbock) and THSteps Specimen Collection Training (Austin, Waco, San Antonio, Laredo, El Paso, Seguin, Victoria). Two exhibits were manned at the Public Health Nursing Conference (2/03) and the Vital Statistics Conference(12/02).

Activity 2: Educate parents and health professionals about newborn screening benefits and state requirements by: 1) distributing brochures on newborn screening to health care providers, 2) placing information regarding newborn screening on the newborn screening website, and 3) making an email address available for any questions regarding newborn screening.

Update: 165,669 educational materials about newborn screening benefits targeting parents and health professionals were distributed during the first three quarters of FY 2003. These included brochures on newborn screening, new submitter packets, posters and magnets.

The website continues to be a useful tool in educating various parties on newborn screening benefits and state requirements. 241,449 web site visits have been made to date. New website additions or postings include: HIPAA links, newsletters, PKU connections Newsletter, 2001 Sickle Cell Disease Guidelines, PKU Medical Foods Pilot Final Report to the Texas State Legislature, Galactosemia Food Card, congenital hypothyroidism and congenital adrenal hyperplasia brochure. Most are available in both Spanish and English.Targeted solicitations included hospitals [(318 contacts, 51 responses, brochures distributed (27,325), 2nd Screen ReReminder magnets (8,067), Specimen Collection Guides (591) and Schools of Nursing Nursing [(395 contacts, 15 responses, brochures distributed (671), specimen collection guides (771).

c. Plan for Coming Year (FY 04):

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory Quality Assurance Officer will provide quarterly unsatisfactory specimen collection reports to the Case Management Program and assist in developing training and educational materials.

Output Measure: Percent of total newborn screens which are unsatisfactory; number of providers identified as submitting unsatisfactory specimens; number of contacts made with providers identified as submitting unsatisfactory specimens; number and type of educational materials distributed.

Monitoring: Quarterly review of percent increase/decrease in unsatisfactory specimens.

Evaluation: Analyze data to determine number of unsatisfactory screens before and dissemination of educational materials

Activity 2: Educate parents and health professionals about newborn screening benefit and state requirements by: 1) distributing brochures on newborn

screening to health care providers, 2) placing information regarding newborn screening on the newborn screening website, and 3) making an email address available for any questions regarding newborn screening.

Output Measure: Type and number of materials distributed and website hits.

Monitoring: Ensure distribution of materials and document interactions with stakeholders.

Evaluation: Analyze NBS data to define the number of missed screens before and after dissemination of educational materials.

National Performance Measure 02 – The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN Survey)

a. Last Year's Accomplishments (FY 02):

This is a new measure - please see the plan for the coming year for more information.

b. Current Activities (FY 03):

This is a new activity. Please see the plan for the coming year to identify ongoing activities.

Activity 1: Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family networking (e.g. through the CSHCN Advisory Committee and/or other related and established committees and councils having CSHCN family representatives, focus groups, ad hoc groups/task forces, input from case management contacts/activities, etc)

Output Measure: Number of CSHCN consumers attending CSHCN policy and networking related meetings; number of opportunities (i.e., meetings, forums, etc.) in which families of CSHCN were involved and provided input.

Monitoring: Collect data on CSHCN family participation on an ongoing basis and document partnership activities.

Evaluation: Annual review of CSHCN family partnering mechanisms to assess the extent of partnering and consumer involvement in decision-making.

Activity 2: Require and confirm that all service contractors have quality assurance plans and provide technical assistance and training to service contractors (in anticipation of FY 05 application, reporting, and monitoring requirements) so that by FY 05 all the quality assurance plans include ways to

measure progress toward the Title V CSHCN national performance measure of family partnership and satisfaction.

Output Measure: Number of contractors with existing quality assurance plans, and activities to prepare/develop contractor quality assurance plans to include ways of measuring and reporting progress toward the national performance measure of CSHCN family partnership and satisfaction (e.g., number of contractors who complete satisfaction surveys;numbers of contractors who do not complete surveys; number of families responding to surveys; and overall response rate.

Monitoring: Monitoring of quality assurance plans and development of activities.

Evaluation: Document that quality assurance plans are established so that in FY 05 contractors will measure and report progress toward the national performance measure of CSHCN family partnership and satisfaction.

National Performance Measure 03 – The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

a. **Last Year's Accomplishments (FY 02):**

This is a new measure - please see the plan for the coming year for more information.

b. Current Activities (FY 03):

This is a new activity. Please see the plan for the coming year to identify ongoing activities.

c. Plan for the Coming Year (FY 04):

Activity 1: Inform CSHCN medical providers and families of the principles and practice of providing/obtaining and utilizing a medical home through participation in the Texas Medical Home Training Conference and through dissemination of materials (including articles and references) of best practices and education/training opportunities on this topic in the CSHCN Program's provider bulletin, family newsletter, and via the CSHCN website.

Output Measure: Number and type of related activities conducted by CSHCN staff to include meetings attended and number of articles and references provided via bulletins, newsletters and website; number of CSHCN providers participating in the Medical Home Training Conference; and number of others who received the materials.

Monitoring: Quarterly reporting on meetings attended, and articles, references, and education/training opportunities promoted.

Evaluation: Amount and type of staff participation in related meetings and the volume of information produced and disseminated.

Activity 2: Document case management efforts (staff and contractors) to connect CSHCN with medical homes.

Output Measure: Policies in place with regional offices and with CSHCN contractors pertaining to client connection to medical homes.

Monitoring: Data from regional case management staff and from service contractors' quarterly reports.

Evaluation: Assess trends in data collected.

National Performance Measure 04 – The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

a. Last Year's Accomplishments (FY 02):

This is a new measure - please see the plan for the coming year for more information.

b. Current Activities (FY 03):

This is a new activity. Please see the plan for the coming year to identify ongoing activities.

c. **Plan for Coming Year (FY 04)**:

Activity 1: Document payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance.

Output Measure: Number of CSHCN by age and region for whom the CSHCN Program pays insurance premiums.

Monitoring: Periodic data collection on schedule.

Evaluation: Assess trends in data collected.

Activity 2: Document provision of health care benefits to those eligible for CSHCN services.

Output Measure: The number of CSHCN by age and region for receiving health care benefits through the CSHCN program.

Monitoring: Periodic data collection on schedule.

Evaluation: Assess trends in data collected.

Activity 3: Document the number of CSHCN on the waiting list by age and region who have no other source of insurance.

Output Measure: Number of CSHCN by age and region who are on the program's waiting list who have no other source of insurance.

Monitoring: Periodic data collection on schedule.

Evaluation: Assess trends in data collected.

National Performance Measure 05 – Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments (FY 02):

This is a new measure - please see the plan for the coming year for more information.

b. Current Activities (FY 03):

This is a new activity. Please see the plan for the coming year to identify ongoing activities.

c. Plan for Coming Year (FY 04):

Activity 1: Continue to fund contracts to support community-based service systems' infrastructure organization and coordination.

Output Measure: Number of contracts funded that support community-based service systems; projected number of families using these community based service systems.

Monitoring: Quarterly reporting on contracted activities that address infrastructure organization and coordination and progress on development of contractor quality assurance plans to measure and report on the national performance measures.

Evaluation: Documentation of contractor funding, activities, and quality assurance plans to ensure that systems are organized and easy to use.

Activity 2: Continue to publicize and gather/monitor public input and feedback on the program and service delivery via the toll free information and referral line, as well as the CSHCN Program website.

Output Measure: Number of calls to the information and referral line and number of hits on the CSHCN website.

Monitoring: Review quarterly website and information and referral line reports for trends in input/feedback.

Evaluation: Identification of trends in positive and negative feedback from consumers and providers.

Activity 3: Continue participation in state-level advisory groups, task forces, committees and similar forums that are working on issues pertaining to CSHCN.

Output Measure: Number of relevant groups and meetings that include CSHCN Program staff participation; number and type of major issues addressed.

Monitoring: Quarterly reporting of specific roles, responsibilities, activities and outcomes resulting from CSHCN Program staff participation in these efforts.

Evaluation: Documentation of staff participation and major issues addressed.

National Performance Measure 06 – The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments (FY 02):

This is a new measure - please see the plan for the coming year for more information.

b. Current Activities (FY 03):

This is a new activity. Please see the plan for the coming year to identify ongoing activities.

c. Plan for Coming Year (FY 04):

Activity 1: Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilities, activities and outcomes.

Output Measure: Number of meetings that include CSHCN Program staff participation; number and types of activities addressed and/or planned.

Monitoring: Quarterly reporting of specific roles, responsibilities, and activities of the CSHCN Program staff in these efforts.

Evaluation: Documentation of staff participation and types of activities addressed and planned.

Activity 2: Provide articles and references on best practices and education/training tools on transition, for CSHCN for families of and/or providers via the Family Newsletter, Provider Bulletin, CSHCN website, and as possible through mail outs with various partners (e.g. advocacy groups, professional organizations, CHIP/Medicaid providers, etc.).

Output Measure: Number of articles, references, education/training tools provided; number of publications information printed in; number of mail outs participating in.

Monitoring: Quarterly tracking and documentation of these efforts.

Evaluation: Volume of information produced and disseminated and feedback resulting from articles on transition issues related to CSHCN.

National Performance Measure 07 – Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Infuenza and Hepatitis B.

a. Last Year's Accomplishments (FY 02):

Activity 1: The Take Time for Kids Program will contract with Texas A&M Extension Service (TES)to continue conducting parent education train-the-trainer workshops for professionals, daycare staff, and community leaders.

Update: Of the 11 workshops planned, the TES conducted 9 parent education train-the trainer workshops for professionals, childcare staff, and community leaders throughout FY 2002. Participants included representatives from public health, WIC, community social service agencies, educators, school nurses and community coalitions. 230 trainers were trained and 250 parents in 11 counties were educated with the materials presented. An evaluation,administered at the end of the workshop, showed an overall satisfaction with workshop presenters and workshop materials. Between 41.6 and 61% of parent educators indicated they used the workshop materials and information. A phone survey, designed for use two months after parents attended the workshop to measure parent knowledge, skills and attitudes was conducted. Though only 85 successful

phone contacts were made due to wrong or disconnected numbers, etc., over 50% of those contacted reported that their child had received the necessary age-appropriate immunizations.

Activity 2:The Take Time for Kids program will develop and distribute a parent education magazine for parents of Medicaid children birth thru 12 months of age. The magazine will inform parents of medical check-ups and immunizations along with other age appropriate information on nutrition, child development, and basic care of the child.

Update: During the first 6 months of FY 02, there were approximately 215,000 English and 90,000 Spanish language issues of the magazine distributed. Publication and distribution of the magazine were discontinued due to funding issues and no copies of the magazine were distributed for the remainder of the year. The "Take Time for Kids" magazine has been adapted at the Federal level to be printed and distributed nationally. The Bush Administration has asked that this series of booklets be renamed and distributed by the U.S. Departments of Agriculture, Education, Department of Health and Human Services. The national name of the magazine is "Health Start, Grow Smart."

Activity 3: Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well child check ups for age according to the periodicity schedule.

Update: Staff monitored Title V contractors compliance with a number of criteria. One of those requirements is that 90% of children be current on well-child check ups for age periodicity schedule. For FY 02, 21 of the 22 contractors who provide child health services were documented as having a system to ensure this.

b. Current Activities (FY 03):

Activity 1: Renew the contract with Texas A&M Extension Service to conduct parent education train-the-trainer workshops for professionals, daycare staff, and community leaders. The purpose is to increase parents' knowledge and skills about the importance of well-child check-ups, immunizations, and other children's health issues.

Update: In 3rd quarter of FY 03, 4 parent education workshops were conducted. 61 professionals were trained to be trainers who represented Even Start, Head Start and other community agencies such as, Avance and the Dallas Independent School District. The training included information on how to plan, implement, and evaluate the parenting program and how to present information on child development, communication, self-esteem, and discipline, nutrition,

health and safety. Each participant received a free copy of the curriculum and handouts accompanied by a CD containing all of the corresponding PowerPoint presentations. The train-the-trainer workshops have expanded into areas of Beaumont, Fort Worth and Houston.

Activity 2: In order to improve immunization rates in Texas, develop recommendations to be included in the comprehensive state plan and presented to the TDH Board of Health.

Update: To improve immunization rates in Texas, the TDH chartered the TDH Internal Immunization Improvement Workgroup in August 2002. The project's purpose was to "identify the opportunities to unite the various TDH resources and overcome any internal barriers, thus enabling TDH to improve immunization levels among the children and adult populations of Texas." TDH created the internal workgroup to build on external stakeholder meetings conducted earlier in various communities throughout Texas, which identified barriers, brainstormed solutions and ended with most participants making a written commitment to the goal of improving immunization rates in Texas. Two plans emerged from these external and internal reviews; Immunizing Texas: A Statewide Plan to Increase Immunization Rates in Texas (September 2002) and TDH 2003-2004 Immunization Improvement Plan Recommendations of the Internal Immunization Improvement Workgroup (November 2002). Implementation of the identified recommendations is being planned.

Activity 3: Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well-child check ups for age according to the periodicity schedule.

Update: In FY 02 and early FY 03, the instrument used by the TDH's Quality Assurance Divisions monitoring staff was revised and the question related to this performance measure was removed. Therefore, no data was collected for this performance measure in FY 2003.

c. Plan for Coming Year (FY 04):

Activity 1: As a Health Child Care America grantee, the Child Wellness Division will develop a plan with the TDH Immunization Division to promote timely, age-appropriate immunizations through the use of the IMMTRAC system (immunization registry) by child care centers.

Output Measure: Number of childcare centers whose staff has been trained to monitor immunization rates through the IMMTRAC computer system; number of staff trained.

Monitoring: Track the number of trained child care centers quarterly through the IMMTRAC system.

Evaluation: Assess changes in the immunization rates of child care centers who implemented IMMTRAC system.

National Performance Measure 08 – The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

a. Last Year's Accomplishments (FY 02):

Activity 1: Provide family planning clinical and educational services to adolescents in regional offices of the Texas Department of Health or through TDH contractors.

Update: TDH regional offices and contractors continued to provide family planning clinical and educational services to adolescents during FY 02. Of the 32,602 receiving services (from a variety of funding sources) 4.721 or 20% were Title V clients. Based on a county by county review, 10 Texas counties, have no teenagers enrolled in family planning services by any funding source.

Activity 2: Develop and distribute resource materials to raise public awareness of teen pregnancy among Hispanic and African American female teenagers aged 13-17 years.

Update: A 36 page folder (called the Teen Pregnancy Prevention Packet) was developed and provides readers with information about the scope and consequences of teen pregnancy, as well as best practice prevention strategies and other resources. 158 packets were distributed to a variety of partners. Portions of the packet were distributed to about 300 TDH HIV/STD contractors. Several pages of the packet have been translated into Spanish. The Bureau of Women's Health also oversees 5 male involvement projects designed to reduce and eliminate teen pregnancy. Of these projects, three target Hispanic teens, one targets both Hispanic and African American teens and one targets mixed ethnicities. A pamphlet was developed that targeted providers. The program does not track how many pamphlets were distributed.

Activity 3: Coordinate with the Take Time for Kids Program (TTFK) to provide information for community/local awareness campaigns in geographic areas with the highest rates of black perinatal mortality.

Update: Due to focus on other priorities and lack of overall funding, the TTFK Program was disassembled in FY 02. Technical assistance was provided in the form of meetings with public health regional staff and presenting them with data regarding perinatal mortality for their respective regions.

Activity 4: Provide funding for community-based abstinence projects for adolescents and teenagers.

Update: The Abstinence Education Program had 32 contractors in FY2002. The state program continued a media campaign with TV spots targeting parents, continued a web page targeting children and began developing an educational video and handbook to help parents talk to their children about sex and abstinence. About 29,972 television spots were delivered in 13 TV and 18 radio markets. The website receives about 900 hits per month. In FY02, Abstinence Program served about 392,801 clients that included adolescents, parents/caretakers, teachers, health care providers and community leaders.

Activity 5: Provide funding for population-based activities to reduce and prevent pregnancy among adolescents and teenagers.

Update: 15 contractors received Title V funding, 37 received Title X and 67 received Title XX.

b. Current Activities (FY 03):

Activity 1: Provide family planning clinical and educational services to adolescents in TDH regional offices or through TDH contractors.

Update: In FY 03, 21,803 teens, aged 15-17, were enrolled in family planning services. Services were funded by Title V, Title X, Title XIX and Title XX.

Activity 2: Develop and distribute resource materials to raise public awareness of teen pregnancy among Hispanic and African American female teenagers aged 13-17 years.

Update: To date, in FY 03, no print materials, including teen pregnancy prevention packets, have been produced or distributed. Teen pregnancy packets contain a variety of resources on the issue of preventing teen pregnancy. Instead, information has been made available to family planning contractors via the program's website. All materials are currently on a secure site; options for making them available for the general public are being explored.

Activity 3: Provide funding for community-based abstinence projects for adolescents and teenagers.

Update: The Abstinence Education Program has served a total of 328,656 clients to date in FY 2003 and the program has a total of 33 contractors located in all but one of Texas' 11 public health regions.

Activity 4: Provide funding to Title V contractors for population-based activities to reduce and prevent pregnancy among adolescents and teenagers.

Update: FY 03 is a continuation year for funding to Title V contractors for this activity. In FY 03, to date, 97 agencies have provided services to reduce and prevent pregnancy in adolescents and teenagers. These agencies have a total of 387 clinics associated with their agencies.

c. Plan for Coming Year (FY 04):

Activity 1: Develop and provide via the Internet, resource materials to raise public awareness of teen pregnancy in Texas, including teen pregnancy rates among Hispanic and African American female teenagers less than 17 years.

Output Measure: Number and types of materials uploaded to the web site; number of hits to the Teen Pregnancy Prevention Page of the Women's Health Website.

Monitoring: Ensure and monitor development and provision of resource materials; track the number of hits to the web site

Evaluation: Assess the usefulness of web-based teen pregnancy prevention materials via an annual poll, to include input from contractors and the Family Planning Advisory Committee. Evaluate changes in teen pregnancy rate in Texas.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Output Measure: Number of unduplicated clients served, including teens/children, parents, and health providers that are provided with abstinence education information. Document the age, ethnicity, and service delivery area served for unduplicated clients.

Monitoring: Review abstinence contractor reports of the number of unduplicated clients and the areas served on a monthly basis. Provide technical assistance to improve contractor performance.

Evaluation: Determine contractor goals for the projected number of clients to be served, and review contractor performance from monthly reports.

Activity 3: Provide funding to Title V contractors for population-based activities and family planning services to reduce and prevent pregnancy among adolescents and teenagers.

Output Measure: Number of contractors involved in teen pregnancy prevention activities; number of contractors providing family planning services.

Monitoring: Review TDH contractor progress reports on a quarterly basis.

Evaluation: Assess any change in the birth rate for teenagers aged 15-17 years by county or region.

Activity 4: Funding awarded to Title XX contractors for family planning activities to reduce and prevent pregnancy among adolescents and teenagers.

Output Measure: Number of contractors involved in providing family planning services to the teen population.

Monitoring: Review TDH contractor progress reports on a quarterly basis.

Evaluation: Assess any change in the birthrate for teenagers aged 15-17 years by county or region.

National Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments (FY 02):

Activity 1: Conduct statewide survey to measure the prevalence of dental sealants among third graders.

Update: The regional dental directors (RDD) conducted surveys from around the state on the prevalence of dental sealants among third graders. Data for the survey were collected by RDDs performing oral exams on third graders at selected elementary schools across the state during sealant clinics. These children were part of the schools' free and/or reduced lunch program. Only children who had parental permission were examined. The results from the statewide survey showed that of the 7,072 third graders examined, 46% or 3,238 had received dental sealants.

Activity 2: Continue statewide promotion of sealant benefits by distributing educational materials for parents and teaching Oral Health curriculum to children in selected Texas schools.

Update: 40,310 Texas children received oral health education during FY 02. Regional dental directors, hygienists, and health educatiors conducted train-the-trainer workshops to teachers and other educators throughout the state. In FY 02, 2 training modules, the "Tattle Tooth " Curriculum and "By the Roots" were used. About 40, 310 Texas students received oral health education (18,643 received "Tattle Tooth" and 21,667 received "By the Roots). Each curriculum ties good oral health practices to essential educational elements and is designed to prepare the trainer to deliver the curriculum directly as well as training other trainers. Use of the "Tattle Tooth" curriculum is being phased out and being

replaced by the “By the Roots” curriculum. “By the Roots” is an interactive curriculum taught by dental health professionals that uses animal skulls, role-playing and hands on demonstrations with dental instruments to teach good oral health practice. Educational information about sealants is no longer sent directly to children’s homes due to funding issues. FY 02 reported activity reflects actual number of children (40,310) receiving oral health education.

b. Current Activities (FY 03):

Activity 1: Conduct statewide survey to measure the prevalence of dental sealants among third graders

Update: Of 3,550 third graders examined, 1,538 (43%) had sealants on at least one permanent tooth. Information specific to molar teeth is currently not collected.

Activity 2: Continue statewide promotion of sealant benefits by distributing educational materials for parents and teaching oral health curriculum to children in selected Texas schools, particularly schools in Regions 6 & 11.

Output Measure: Number and type of educational materials distributes; number of children participating in oral health curriculum.

Monitoring: Track TDH regions and schools participating in the oral health curriculum.

Evaluation: Conduct a pre- and post- test survey on 3rd graders who received the oral health curriculum.

Update: Education sealant brochures were given to each child receiving sealants. Additional educational instruction was provided to 179,187 individuals.

c. Plan for Coming Year (FY 04):

Activity 1: Continue providing dental sealants to Texas’ 3rd grade population.

Output Measure: Number of third graders who received dental sealants.

Monitoring: Track progress of the data collection and analysis.

Evaluation: Assess any changes in the percentage of third graders receiving dental sealants.

National Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments (FY 02):

Activity 1: Expand parenting education opportunities regarding car seat safety for children birth thru 4 years of age through the Take Time for Kids Parent Education Workshops, particularly among African American families.

Update: Seven train-the trainer 32-Hour Child Passenger Safety (CPS) workshops were conducted across Texas. 184 participants trained to become CPS Technicians. . Each of these CPS technicians will educate parents in their community about the safe transport of their children and the correct way to install their child's safety seat.

Activity 2: Provide traffic-safety presentations to children ages 3-14 regarding bicycle and car seat safety, particularly among African American families.

Update: A total of 154 traffic-safety presentations throughout Texas were conducted with 2,800 children and parents receiving information and instruction regarding car seat safety. Verbal pre- and post-tests for children were conducted and pre- and post-written tests for adults were conducted. Test results indicated an increase in safety seat knowledge. Parents and children listened intently and participated actively in the presentations.

Activity 3: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from ages birth to about age 6.

Update: A total of 20,291 safety seats were distributed to low-income families in Texas during FY 02. The Emergency Medical Services system distributed 17,010 seats in 93 locations and 3,281 were distributed through the 73 Traffic Safety Distribution programs. Information on age of recipients of seats is not currently collected. Parents or caregivers calling the Traffic Safety 1-800 number to inquire about a safety seat are directed to a distribution program near them. Each parent receiving a seat was educated about the safe transport of their child and how to install the seat correctly. This program was very successful and resulted in many families in Texas receiving safety seats and related education as a result. One child that we know of was saved because of a safety seat provided by this project.

b.. Current Activities (FY 03):

Activity 1: Provide traffic-safety presentations to children ages 0-8 regarding bicycle and car seat safety.

Safe Riders does not have a bike helmet program, but the program does order low cost helmets through SAFE KIDS when requested by community groups.

Low cost bike helmets were ordered for four agencies between November 2002 and April 2003. A total of 340 helmets were ordered.

Since September 2002, the Safe Riders Traffic Safety Program provided 50 child passenger safety presentation to a total of 969 children/adults. Records of attendance (including number of participants) are maintained in central office. A monthly calendar of upcoming events is sent statewide to TxDOT Traffic Safety Specialists and TxDOT central office in Austin.

Children are asked questions before and after the presentation to determine what they learned and understand. Children always enjoy sharing their knowledge. Adults are questioned after the presentation to determine if they understand and have learned the presented information. The traffic safety information presented is reviewed and summarized after each presentation.

Activity 2: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.

The state safety seat distribution program ordered a total of 11, 064 seats on May 16, 2003. Seats were sent directly to the 113 safety seat distribution programs and are pending distribution. These seats are provided from the Texas Department of Transportation federal pass through funds.

The site (www.state.tx.us /injury/safe) distribution application was posted on the Safe Riders website in December 2002 and January 2003. Over 254 applications were received and 113 applications were selected as safety seat distribution programs following a scored selection process. Agencies to receive seats were notified in March 2003. All agencies selected are required to send at least one person to attend a four-hour training before the agency can distribute their seats to low-income families. Currently, staff trained as certified Child Passenger Safety Seat Technicians are training the 113 programs statewide to orient them to the program. As of May 2003, nine (9) distribution training sessions had been held and the number of persons receiving training was 97.

c. Plan for Coming Year (FY 04):

Activity 1: Continue providing dental sealants to Texas' 3rd grade population.

Output Measure: Number of third graders who received dental sealants.

Monitoring: Track progress of the data collection and analysis.

Evaluation: Assess any changes in the percentage of third graders receiving dental sealants.

National Performance Measure 11: Percentage of mothers who breastfeed their infants at hospital discharge.

a. Last Year's Accomplishments (FY 02):

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs Mother's Survey and the WIC program.

Update: For FY 02, 59% of mothers had breast-fed their babies' while in the hospital, a one-percent point increase over what was reported in FY 01. About 20% reported breastfeeding at 6 months of age. Breastfeeding rates remained fairly steady during the year with only a 2 percent increase from September 01 (59.7%) to September 02 (61.7%).

Activity 2: Improve community access to educational and support resources to promote breastfeeding by providing multiple venues such as, maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American Families.

Update: 297 attendees (nurses, doctors, dieticians, others) attended the Texas Breasfeeding Summit. 23 people participated in the TDH-sponsored Peer Counselor Train-the-Trainer Program in FY02. The purpose of this train the trainer program is to provide the trainers with information and resources in order to establish a peer counselor program and train prospective peer counselors on the promotion and management of breastfeeding. A total of 199 participants attended WIC Peer Counselor training conducted by WIC Local Agencies in FY02. Of these, 122 were WIC participants, 64 were WIC staff and 13 were non-WIC. In FY02, the Speakers' Bureau was managed completely on the Texas Breastfeeding Activities Web page. Interested speakers completed a form that was submitted electronically to TDH and information about the individual was then placed on the website as a resource for people seeking speakers on breastfeeding topics. No statistics were kept on how often the speakers' bureau segment of the web page was accessed. For the 11 months of FY02 for which data are available, approximately 97,011 hits were made to the TDH Breastfeeding website.

Activity 3: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Hospital Initiative.

Update: In FY 2002 there were 61 requests for training and 57 were honored through the provision of the Mini Basics I or Mini Basics II referenced in Activity 4 below. Four scheduled training sessions were cancelled at the requestor's request due to other factors. To date, there are a total of 29 accredited hospitals or birthing centers in Texas.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods including distribution of educational materials and conducting training programs.

Update: There are 5 types of breastfeeding training offered by TDH. There are two Mini-basics courses, Mini 1 and Mini 2, which are one-day sessions that give basic information on breastfeeding promotion and support. Mini Breastfeeding I was provided 33 times and Mini Breastfeeding II was provided 24 times during FY 02.

b. Current Activities (FY 03):

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs Mothers Survey and the WIC program.

Update: During the first three quarters of FY 03, the WIC breastfeeding rate increased from 61.6 to 62.3.

Activity 2: Improve community access to educational and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American families.

Update: The number of WIC peer counselors is not available on a quarterly basis. Local WIC agencies are surveyed once a year to obtain this information. The information for FY 03 will be available in September 03 when it is tabulated for the end of the year funding report to USDA. Peer Counselor Train-the-Trainer training sessions continue. As of May 2003, 9 train-the-trainers attended the training sessions. The Texas Breastfeeding Initiative Website remains a valuable and often used resource for information promoting breastfeeding. 84,435 hits have been recording on the breastfeeding promotion website.

The Fifth Annual Breastfeeding Summit was held Sept.30 – Oct 2,2002 in San Antonio, Texas. High profile subject matter speakers and many more gave presentations on topics ranging from the impact of ankyloglossi on breastfeeding to birthing a breastfed baby to health perspectives for the Mother-Bay Dyad. 168 nurses or LVNs, 10 MDs and PAs, 36 RD/DTR and 111 others attended for a total of 325 summit participants.

Activity 3: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Hospital Initiative.

Update: To date (5/31/03) in FY 03, no letters (generating applications) were sent to hospitals regarding accreditation, five hospitals have applied and been reviewed, and two new hospitals and/or birthing centers accredited. Three

applications, which have not been accredited, have been reviewed to identify reasons for denial and appropriate follow-up undertaken.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Update: There is currently no way to track the number of health care professionals recommending breastfeeding as the health care provider survey is no longer being distributed due to funding issues. Health care provider packets are no longer being distributed. All training requests have been met. In the first three quarters of FY 03, there were 7 Phase One, 7 Phase Two and 20 Mini-Basic trainings conducted. Each training has a different focuses and concentrations, but all relate to the promotion of breastfeeding. 1,361 participants have completed the training.

c. Plan for Coming Year (FY 04):

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.

Output Measure: Percent of mothers breastfeeding at hospital discharge.

Monitoring: Review WIC, Ross Labs and PRAMS data on a quarterly basis

Evaluation: Analyze available data to identify the characteristics of breastfeeding mothers and non-breastfeeding mothers at hospital discharge.

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American families.

Output Measure: Number of WIC breastfeeding peer counselors by race/ethnicity; number of volunteer breastfeeding peer counselors by race/ethnicity; number of WIC and non-WIC participants attending the train-the-trainer Peer Counselor program training by race/ethnicity; number of hits to the breastfeeding website.

Monitoring: Review quarterly progress reports from website; review training participants' evaluation forms.

Evaluation: Evaluate the use of the different types of resources developed and other specific types of requests for information and support by 1) having training session participants complete evaluations and 2) other ad hoc measures such as

an annual survey to WIC local agencies, Title V contractors, health care providers, and hospitals.

Activity 3: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Hospital Initiative.

Output Measure: Number of packets sent to hospitals requesting accreditation; number of new hospitals and birthing centers accredited. Frequently Asked Question (FAQ) document developed to assist hospitals in being accredited as a Texas Ten Step Hospital; FAQ published on the website.

Monitoring: Track progress in providing training and technical assistance as requested.

Evaluation: Determine the number of hospitals and birthing centers that applied but were denied accreditation and follow-up to identify reasons.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Output Measure: Number of training sessions provided; number of physicians or health care professionals participating in training by race and ethnicity; number of physician's pocket guides distributed to health care professionals.

Monitoring: Track progresses in providing training and technical assistance as requested; document training schedule and attendance.

Evaluation: Determine if there was an increase in percent of women breastfeeding at hospital discharge

National Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

a. Last Year's Accomplishments (FY 02):

Activity 1: Conduct monitoring of newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Update: Of the total number of hospitals/birthing facilities mandated by state law to conduct newborn hearing screening, the number of hospitals/birthing facilities in compliance increased during the year to a total of 98% by the end of FY 02. The number of mandated hospitals/birthing facilities varies throughout the year as new hospitals/birthing facilities open and others close. During FY02, the number of hospitals covered by this mandate ranged from 173 to 180. During FY

02 the compliance rate for numbers of newborns' hearing screened continued to increase from 96% in FY 01 to 98% in FY 02. On-site monitoring visits were eliminated by the electronic transmission system of data and quality controls built into that system. The program monitors how many newborns are screened as well as how many pass/fail in any given year.

b. Current Activities (FY 03):

Activity 1: Conduct monitoring of newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Update: On a weekly basis, Texas birthing facilities covered by the newborn hearing screening mandate electronically transmit to the TDH contractor the records of all babies screened. The TDH contractor tabulates the results on a monthly basis. Birthing facilities are required by Texas law to be certified by the TDH and meet specific performance standards. Facilities are noted as being out of compliance if their facility is below any of the standards for two (2) of the three (3) months in a quarter. Currently there are 194 birthing facilities reporting data to TDH on a quarterly basis. On average for each of the first three quarters of FY 2003 97% of newborns are screened.

c. Plan for Coming Year (FY 04):

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Output Measure: Number of programs monitored by region, percent of compliant versus non-compliant programs.

Monitoring: Document the results of monitoring through monthly reports generated by electronic monitoring system developed for this project.

Evaluation: Assess the level of compliance with certification criteria.

National Performance Measure 13: Percent of children without health insurance.

a. Last Year's Accomplishments (FY 02):

Activity 1: Monitor and report the percentage of children without health insurance.

Update: In FY 2002, there were 1,275,099 or about 21.3% of the total children without health insurance in Texas.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and refer to CHIP and Medicaid.

Update: Of those clients who presented for health care at Title V-funded clinics, an estimate of 55% of the clients were screened and referred to other programs, mainly to Medicaid and CHIP.

b. Current Activities (FY 03):

Activity 1: Monitor and report the percentage of children without health insurance.

Update: Title V staff proactively monitor CHIP and Medicaid enrollment figures on a monthly basis and continue to monitor the number of eligible clients who are receiving services through Title V contractors.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Update: As required, all Title V contractors actively screen all clients at Title V funded clinics for potential CHIP and Medicaid determination and make referrals as appropriate.

c. Plan for Coming Year (FY04):

Activity 1: Monitor and report the percentage of children without health insurance.

Output Measure: Percent of children without health insurance.

Monitoring: Follow progress in developing periodic child health insurance status report.

Evaluation: Examine trends in child health insurance coverage and use data in program planning and interagency coordination efforts to increase the percentage of children with insurance coverage.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Output Measure: Percentage of children without health insurance identified by Title V contractors and referred to CHIP and other state-funded insurance programs.

Monitoring: Follow up on each referral.

Evaluation: Assess the number of children without health insurance who are identified by Title V contractors and referred to CHIP and other state-funded insurance programs.

National Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments (FY 02):

Activity 1: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible. Update: In FY 2002, 1,661,900 children were potentially eligible for Medicaid. Of those, 726,473 (44.5%) received a service paid by the Medicaid program.

b. Current Activities (FY 03):

Activity 1: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.

Title V staff work closely with the Research and Public Health Assessment Division and the Texas Health Steps (EPSDT) program to monitor the ratio of Medicaid child recipients receiving Medicaid services. Analysis are done on an annual basis at the time of the grant renewal.

c. Plan for Coming Year (FY 04):

Activity 1: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.

Output Measure: Number of Medicaid children birth through age 20 who received a Medicaid service, number of children birth through age 20 who are potentially Medicaid eligible.

Monitoring: Follow progress in updating report.

Evaluation: Analyze trends of the number of potentially Medicaid eligible receiving a Medicaid paid service.

National Performance Measure 15: The percent of very low birth weight infants among all live births.

Last Year's Accomplishments (FY 02):

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk and consult with providers to implement strategies to reduce the occurrence of very low birth weight live births.

Update: In July/August of 02, presentations were given in 7 regions. These presentations included data on low birth weight, infant mortality, and initiation of prenatal care specific to each public health region. Attendees were Title V staff, local contractors, representatives from local health departments and community-based organizations. Outcomes of the presentations were enhanced sharing of information about MCH programs and activities; enhanced sharing of MCH data at the county, region and state level; better understanding among participants of the barriers and issued faced in the regions regarding MCH; development, fostering and building working collaborative relationships; enhanced communication forums; and discussion on several key indicators of poor MCH outcomes and how they impact the region. TDH maternity standards which give health care providers minimum standards for prenatal care were revised in FY 02 by a collaborative committee. After the standards were approved, they were made available to all TDH contractors and any interested health care providers via the TDH website.

Activity 2: Develop and implement a state strategic plan to address barriers to reduce the prevention of perinatal HIV transmission.

Update: Title V and HIV/STD Prevention staff and other internal and external stakeholders, met in FY 02 to develop, refine, and begin implementation of a 3-part plan to reduce Perinatal HIV transmission. The plan included creating a data inventory, developing a social marketing campaign and a survey of physicians regarding practices and training needs. The plan's priority areas included: an HIV Perinatal Social Marketing campaign; data assessment and reorganization for greater usefulness; and provider identification and training, including development of a list of barriers to care and strategies to overcome those barriers.

Activity 3: Devise a plan to address the role of perinatal HIV transmission in the high rate of black perinatal mortality (this a sub-activity of the activity above).

Update: Through the Perinatal HIV Transmission Project, a priority activity identified was the development of a social marketing campaign to encourage early and regular prenatal care. Data profiles regarding HIV and Perinatal HIV Transmission were shared in 7 regions. The social marketing campaign was put on hold pending availability of funds.

Activity 4: Provide support to implement the Pregnancy Risk Assessment Monitoring System (PRAMS).

Update: Presentations were made to health care providers in each region as well as some statewide trade meetings. At least 25 health care providers participating in training sessions.

b. Current Activities (FY 03):

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk (African American women of childbearing age), and consult with providers to implement strategies to reduce the occurrence of very low birth weight live births.

Update: One presentation was made in PHR 11 to provide TDH staff, local providers and health department staff with data about very low birth weight, as part of a general presentation made to all PHRs. Gestational diabetes was also discussed.

During the first quarter of FY 03, a Title V Perinatal Health staff person participated in a Ft. Worth city wide forum to address infant mortality and has remained involved as a technical advisor as funds and other resources permit. Throughout FY 03, TDH Title V staff worked with DHHS region VI staff and Texas and other Region VI Health Start staffs to develop ways to reduce the incidence of low birth weight and prematurity. TDH staff participation included meeting with Texas Health Start Alliance members to network and share information, provide data, serving on conference planning committees, and attending conferences. In each quarter of FY 03, Title V staff met with the March of Dimes to plan and implement their five-year focus on low birth weight and prematurity. At least two presentations have been made to internal and external stakeholders regarding the MOD initiative.

Activity 2: Develop and implement a state strategic plan to address barriers to reduce the prevention of perinatal HIV transmission.

Update: Meetings commenced in FY 02 between staff in the Bureau of Women's Health and the Bureau of HIV/STD to evaluate progress on the plan have continued into FY 03. Team members communicate regularly on the status of the project. Data profiles regarding HIV in women, infants and children have been developed for the state and for each public health region. The data profiles have been presented to the public health regions and placed on the TDH website. A final report has been developed and submitted to the Association of Maternal and Child Health Programs, the sponsors of the Action Learning Lab on Perinatal HIV Transmission. AMCHP has invited a TDH Title V staff person to speak on the project at the current Perinatal HIV Transmission Action Learning Lab (scheduled for the 4th quarter of FY 03).

Activity 3: Devise a plan to address the role of perinatal HIV transmission in the high rate of black perinatal mortality (this a sub-activity of the activity above).

Update: Due to lack of funding the social marketing campaign of the plan has not been implemented. Program staff is hopeful that implementation will take place when resources are available.

Activity 4: Provide support to implement the Pregnancy Risk Assessment Monitoring System.

Update: Meetings on use of system continue. Response rates to batches of distributed questionnaires average around 55%.

c. Plan for Coming Year (FY 04):

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk (e.g., African American women of childbearing age), and provide regional staff and health care providers with data and information on strategies to reduce the occurrence of very low birth weight live births. Provide data and information on the Perinatal Health website.

Output Measure: Number of areas with very low birth weight births identified; reports that include data presented to regions and local health departments about very low birth weight births at the local level; reports that include strategies developed to prevent very low birth weight births presented to regions and local health departments; number of hits to the Perinatal Health website.

Monitoring: Document dissemination of data and other information to regional and/or local providers located in geographic areas with high percentages of VLBW.

Evaluation: Analyze and profile geographic areas with a high incidence of very low birth weight births before and after the implementation of the strategies.

Activity 2: Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS).

Output Measure: Number of presentations made to providers and stakeholders on PRAMS; the number of providers and stakeholders participating in PRAMS activities; number of PRAMS respondents by batch; PRAMS annual response rate.

Monitoring: Track development and implementation schedule for PRAMS activities; document minutes of meetings with program and PRAMS staff.

Evaluation: Assess the response rate on an annual basis.

Activity 3: Provide ongoing support to the March of Dimes five-year Prematurity Campaign.

Output Measure: Number of conference calls participated in; number of campaign planning meetings participated in; number of presentations made to providers and stakeholders on prematurity; low birth weight and very low birth weight; number of and type of state program services committee meetings participated in; number of March of Dimes data requests filled.

Monitoring: Document minutes of meetings and conference calls with March of Dimes; document agendas of presentations; document filling of data requests.

Evaluation: Assess the prematurity and very low birth weight rates on an annual basis.

National Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

a. Last Year's Accomplishments (FY 02):

Activity 1: Collaborate with the Adolescent Health Program to provide Mental Health C.P.R. resources to local school districts through a loaner program at Regional Education Service Center.

Update: The Adolescent Health Coordinator surveyed the School Health Network (Regional School Health Specialists) to ascertain the need for additional revisions to the Mental Health CPR curriculum. Responses to the survey indicated that training priorities are determined at the local school district level and efforts to create support for school-based suicide interventions strategies were extremely difficult. However, School Health Specialists conducted a total of 212 presentations focusing on suicide in school communities throughout the state. Information from the survey and other feedback will be used by TDH to review current strategies and to develop other effective strategies.

Activity 2: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors among children aged 15-19 years.

Update: During the initial process of planning for this particular performance measure staff were dedicated for the "Youth Health Initiative," however, due to funding shortfalls and a reduction in funding specific to this program, this measure was not evaluated, nor the activities completed. The Youth Health Initiative was planned to focus on promoting the development of resiliency and other protective factors (i.e., asset building) among children aged 15-19 years. The program supporting this particular measure was disbanded, however learned

philosophies relative to youth development and resiliency may often be incorporated in the day-to-day work of those formerly involved.

b. Current Activities (FY 03):

Activity 1: Collaborate with the Adolescent Health Program to provide Mental Health C.P.R. resources to local school districts through a loaner program at Regional Education Service Center.

Update: The Adolescent Health Coordinator surveyed the School Health Network (Regional School Health Specialists) to ascertain the need for additional revisions to the Mental Health CPR curriculum. Responses to the survey indicated that training priorities are determined at the local school district level and efforts to create support for school-based suicide interventions strategies were extremely difficult. However, School Health Specialists conducted a total of 212 presentations focusing on suicide in school communities throughout the state. Information from the survey and other feedback will be used by TDH to review current strategies and to develop other effective strategies.

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c. Plan for Coming Year (FY 04):

Activity 1: In the continued effort to create statewide suicide prevention plan; work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state.

Output Measure: Statewide prevention plan developed; grant funding secured from public and private entities to implement components of the state plan.

Monitoring: Track the progress of the initiative via grants secured and state and local government support.

Evaluation: Assess the overall changes in the suicide rates after activities/plan has been implemented and the level increased awareness in the state of the issue of suicide prevention.

National Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments (FY 02):

Activity 1: Continue the implementation of training and consultation with public health regional staff to establish a regional perinatal care system in order to facilitate interventions to reduce VLBW and other perinatal conditions in their regions.

Update: To date, none of the public health regions has coordinated an implementation plan for a perinatal care system. In Oct. 01, a meeting was held between the Perinatal Health Program Coordinator and PHR 11 staff regarding implementation of perinatal systems. At that time, the elements of a perinatal health system were outlined. To date, PHR 11 has not opted to coordinate a plan, although leadership and staff remain very interested in the possibility.

In July and August of 02, presentations were given in 7 of the 8 combined public health regions (PHR). In these meetings, the concept of perinatal systems was discussed, Geographic Information System (GIS) maps containing information about existing perinatal services in each PHR were presented and discussed and the barriers to regional perinatal systems were identified.

Throughout FY 02, Perinatal Health Program staff and staff from Spatial Approaches to Health Outcomes (SAHO) have worked to identify, geocode and map the elements of perinatal health care systems throughout the State of Texas. These maps have been presented to staff from each of the Texas public health regions. Next steps include making these maps available to the public via the Internet.

By viewing the GIS maps developed by SAHO and the Perinatal Health Program, regional staff can identify where the services that comprise a perinatal systems exist and where there are gaps. They can also determine which services are offered either within their region or in neighboring regions.

Due to restricted funding, any current efforts at conducting strategic planning in perinatal systems will have to be done either through a regional or local effort. To date, PHR 11 (Harlingen) has expressed the most interest in implementing a planning process for perinatal systems. In FY02, there was one consultation session per public health region provided to support regional staff activities and planning for implementation of the voluntary perinatal care system. In addition, a distribution list was created to facilitate communication about perinatal systems

with the regional staff. Finally, Title V staff was available to respond to inquiries or concerns via e-mail and the telephone.

b. Current Activities (FY 03):

Activity 1: Continue the implementation of training and consultation with public health regional staff to establish a regional perinatal care system in order to facilitate interventions to reduce VLBW and other perinatal conditions in their regions.

Update: To date in FY 03, one presentation was made in Public Health Region 11 to provide regional staff, local providers, and local health department staff with Geographic Information Systems (GIS) data about the establishment of regional perinatal systems of care. Previous presentations (7) were made in FY 2002. Due to resource limitations, no additional consultations have been held with health care providers and no work has been done with providers and stakeholders on developing or implementing strategies to encourage the implementation of perinatal systems.

c. Plan for Coming Year (FY 04):

Activity 1: Develop and implement a process for the self-designation of perinatal care facilities as basic, specialty or subspecialty.

Output Measure: Self-designation process developed; number of self-designation process plans implemented; letters about self-declaration process sent to all perinatal care facilities.

Monitoring: Track developments related to development and implementation of process. List perinatal care facilities by designation on the program's website.

Evaluation: Assess the long-term changes in the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

a. Last Year's Accomplishments (FY 02):

Activity 1: Continue to assess the level and type of interventions needed for each geographic area and related sub-populations at risk (Hispanic and African American women of childbearing age) and provide consultation to providers to implement strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester.

Update: In July and August of 02, presentations were given in seven of the eight combined public health regions (the eighth took place in Sept. 02). Depending on the region, the audiences included regional maternal and child health staff, public health region leadership representatives, local health department staff, local health care providers and MCH grantees, as well as representatives from community-based organizations. Each of these presentations included data regarding adequacy of prenatal care by county in each region.

One part of the Perinatal HIV Transmission Project calls for the development of a campaign to encourage early and regular prenatal care as a means of ensuring that pregnant women are tested for HIV. In developing that campaign, campaigns from several other states were reviewed. The review was used a starting point to solidify the state plan to focus the campaign on getting prenatal care more than testing.

Four of the presentations given in the Public Health Regions in 02 included local health care providers. In these meetings, development of strategies to increase prenatal care among the target population was discussed. Specific discussion focused on strategies to increase providers' willingness to take on clients, building partnerships between entities in the prenatal care delivery system and addressing cultural issues around prenatal care. At the state level, one strategy developed to prevent low birth weight babies in FY2002 was the revision of the maternity standards that give health care providers minimum standards for prenatal care. These standards were based on national standards and were developed through a committee that included TDH central office and regional staff. After the standards were approved, they were made available to all TDH contractors and any interested health care providers through the TDH website.

TDH staff also attended the CDC-sponsored Safe Motherhood Summit in Sept. 2001. Information from the Summit was presented to TDH central office and regional staff and interested parties, including community-based organization such as Texas Healthy Mothers, Healthy Babies.

b. Current Activities (FY 03):

Activity 1: Continue to assess the level and type of interventions needed for each geographic area and related sub-populations at risk (Hispanic and African American women of childbearing age) and provide consultation to providers to implement strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester.

One presentation was made in PHR 11 to provide regional staff, local providers, and local health department staff with data about early entry to prenatal care in the region. A social marketing campaign targeting African American women has been in development since FY 2002. Focus group testing among the target population took place in the 1st and 2nd quarters of FY 2003, but due to lack of

funding and other resources, the campaign has not yet been implemented. Staff is hopeful that the campaign will be implemented as soon as funds are available.

c. Plan for Coming Year (FY 04):

Activity 1: Continue to assess the level and type of interventions needed for each geographic area and related sub-populations at risk (Hispanic and African American women of childbearing age) and provide consultation to providers to implement strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester.

One presentation was made in PHR 11 to provide regional staff, local providers, and local health department staff with data about early entry to prenatal care in the region. A social marketing campaign targeting African American women has been in development since FY 2002. Focus group testing among the target population took place in the 1st and 2nd quarters of FY 2003, but due to lack of funding and other resources, the campaign has not yet been implemented. Staff is hopeful that the campaign will be implemented as soon as funds are available.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet: Up to 10 major activities can be listed for each of the National Performance Measures and these activities should be identified by the level of the pyramid. Specific activities may reflect different levels of the pyramid than the corresponding performance measure. To complete Figure 4a, click on the hyperlink above.

Figure 4A is part of Appendix F.

C1. RETIRED NATIONAL PERFORMANCE MEASURES (OPTIONAL)

If desired, you may use the space below to discuss your state's activities addressing the performance measures that were retired with the new guidance. These performance measures are:

Performance Measure 2, The degree to which the State CSHCN program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Performance Measure 3, The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

Performance Measure 4, Percent of newborns in State with at least one screening for each of PKU, hypothyroidism, Galactosemia, Hemoglobinopathies (e.g., sickle cell diseases) (combined).

Performance Measure 11, Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

National Performance Measure 02 - 02 Update: There are a total of 6,596 CSHCN eligibles. 1,305 are on the wait list and 5,291 receive services. 03 Update: There are a total of 4,754 CSHCN eligibles with 1,942 on the wait list.

National Performance Measure 03 - 02 Update: CSHCN continues to support and contribute to workgroups focusing on promulgating best practice associated with the concept of medical home. Over 17 workgrops and task forces requested and included CSHCN specialist' participation in their efforts. Participation in these workgroups raises awareness of the needs of the CSHCN population, educates other service providers on practices related to the concept of medical home, and thus promotes development of more comprehensive systems of service and support. 03 Update: CSHCN worked with HHSC staff in identifying and addressing coverage issues specific to CSHCN when making reimbursement and policy decisions. Staff are assisting in planning the "Every Child Deserves a Medical Home Training Program," scheduled for Fall 03. Teams will be trained and then charged to train others in their local communities on concepts related to medical home.

National Performance Measure 04 - Activities in both 02 and 03 are relevant to new national measure. Please see last year's accomplishments and current activities for the new NPM #1 for an update relevant to this measure.

National Performance Measure 11 - 02 Update: CSHCN staff members who are responsible for medical policy attend monthly Medicaid medical policy and related meetings in an effort to assure coordination of policies wherever possible. Background research for development and revision of CSHCN policies always includes review of current Medicaid and CHIP medical policies. Twenty-eight (28) CSHCN policies were reviewed and 21 (75%) were approved during FY 02. Extensive coordination and collaboration between Medicaid and CSHCN staff was planned for FY 03 related to policy changes necessitated by the implementation of HIPPA. Through these efforts the Title V CSHCN Program attempts to ensure that CSHCN have coordinated and comprehensive health care coverage. 03 Update: CSHCN staff continue to work collaboratively with Medicaid staff at HHSC to align policies between the two programs whenever possible. During FY 03 policy work has concentrated on updates and revisions mandated by the elimination of local codes with implementation of HIPAA. CSHCN staff has attended 80% of bimonthly Medicaid Medical Policy meetings, 80% of monthly Medicaid Pricing Workgroup meetings and many HIPAA related

workgroups meetings. To date for FY 03, 42 CSHCN policies have been reviewed, revised and/or updated.

D. STATE PERFORMANCE MEASURES

State Performance Measure 01: Change in institutionalized CSHCN, as percent of previous year.

a. Last Year's Accomplishments (FY 02):

Activity 1: Participate in the statewide Children's Policy Council (CPC) to collaborate with consumers, providers, and other agencies to support community living options for CSHCN in institutions and congregate care facilities.

Update: The CPC met 7 times in FY 02 and a member of the CSHCN Division staff attended each meeting on an "ex officio" basis to support the work of the CPC. A TDH CSHCN Regional Social Work staff member was appointed to be an official member of this Council by the Commissioner of HHSC and this staff member attends meetings regularly as well.

During FY 02, work was done to identify barriers families encounter when trying to access supports and services and to develop strategies to improve the systems of family supports. The CPC is also involved in implementing a legislative mandate, Senate Bill 36, 77th Legislature requiring cross-agency training for caseworkers and for developing a memorandum of understanding to address the needs of youth transitioning from children's services to adult services. With the assistance of 5 CSHCN Division staff members who participated in the process, CPC issued a report to the Texas Legislature and the HHSC Commissioner in September 02 entitled "And How Are The Children?" The report was the product outcome of the process described above and details the state of services for children with disabilities and chronic illnesses. This report contained 26 recommendations on improvements needed to address the needs of these children in Texas.

Research quoted in this report shows that:

- 231 children under age 21 are in Texas nursing facilities;
- 257 children under age 11 are in facilities classified as "state mental retardation facilities" (This does not include children with a primary diagnosis of mental illness);
- 697 children under age 21 are in Intermediate Care Facilities for the Mentally Retarded;
- 76 children under age 21 are in institutions for mentally retarded licensed by the Texas Department of Protective and Regulatory Services (DPRS);

- 1,261 children under age 21, in total, were in institutions as of June 2002 (as compared to 1,253 in 2001).

These data will provide a baseline for measuring the change in institutionalized CSHCN as a percentage of the previous year

Activity 2: Increase family support services for CSHCN and their families to enable CSHCN to live with their families in the community.

Update: At the beginning of the fiscal year there were 5 clients who were authorized to receive family support services for medical foods. At the end of FY 02, 308 individuals (children plus adults with cystic fibrosis) were on the waiting list specifically for family support services. The CSHCN Advisory Committee, along with the Texas Board of Health, laid the groundwork for establishing a private foundation which may help provide the family supports required to reduce the number of CSHCN who are currently institutionalized.

b. Current Activities (FY 03):

Activity 1: Participate in the statewide Children's Policy Council (CPC) to collaborate with consumers, providers, and other agencies to support community living options for CSHCN in institutions and congregate care facilities.

The CPC met 2 times from Sept. 1 through May 31, 2003. CPC has 18 public members, nine of whom are family representatives as well as one youth member. CPC meetings were primarily focused on legislative issues of the 78th Legislative Session relating to long term care and supports for children with disabilities and special health care needs. CPC authored a report in September 2002 that served as a primary

Activity 2: Provide family support services for CSHCN and their families to enable CSHCN to live with their families in the community tool for informing the legislature on issues of focus.

Four families received family support services (medical foods) from September 2002-May 2003. Additional families were not recipients of family support services due to program and department budgetary constraints. Children served by case management and community/family resource services contractors continued to receive support services such as parent, sibling, and grandparent support groups and activities; educational workshops (topics included Admissions, Review and Dismissal meeting training; transition planning; wills, trusts, and guardianship; understanding the uniqueness of ADHD; and an introduction to behavioral treatment of children with autism and Asperger's syndrome); opportunities for networking with other families; respite care; equipment lending services, resource library lending services; and crisis/emergency funds or supplies (such as diapers, food, clothing, and

assistance with utilities or rent). During the first quarter of FY 2003, 2563 individuals received these and other family support services and during the second quarter of FY 03, 2,305 individuals accessed support services through these contracts.

As of March 27, 2003, program rule changes included family support services in the program's health care benefit definition.

c. Plan for Coming Year (FY 04):

Activity 1: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and community living options for CSHCN who are at risk for placement or who currently reside in institutions and congregate care facilities.

Output Measure: Types of activities involved in and completed.

Monitoring: Documentation of meetings attended by CSHCN Division staff.

Evaluation: Document annual outcomes and products relevant to CSHCN in institutions.

Activity 2: Provide family support services for CSHCN and their families to enable CSHCN to live with their families in the community.

Output Measure: Number of CSHCN and their families obtaining family support services through the central office program as well as CSHCN contractors; number of CSHCN clients and their families requesting but not receiving family support services; number of CSHCN who request CSHCN family support services because they are at risk for institutionalization.

Monitoring: Track CSHCN program utilization, track the number of CSHCN on the waiting list; track expenditures for family support services.

Evaluation: Extent to which families requesting family support services are served.

State Performance Measure 02: Percent of children and adolescent (age 13-19) who chose healthy behavior.

a. Last Year's Accomplishments (FY 02):

Activity 1: Provide training on youth risk reduction and youth health promotion to healthcare and education professionals at regional Education Service Centers.

Update: On average 250 training sessions were held with focuses on tobacco prevention, injury prevention, teen pregnancy prevention and STD training. Some training sessions covered multiple topics.

Activity 2: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors in youth.

Update: This measure was not evaluated, nor the activities completed due to funding shortfalls, however some of the learned philosophies relative to youth development and resiliency are incorporated in various department activities and the day-to-day work of those formerly involved.

Activity 3: Develop and distribute resource materials to raise public awareness of teen pregnancy among Hispanic and African American female teenagers aged 13-17 years.

Update: A Teen Pregnancy Prevention Packet has been developed and distributed. 158 presentations were conducted along with 300 HIV/STD clinics receiving part of the package.

BWH also oversees five male involvement projects designed to reduce and eliminate teen pregancy. Of these projects, 3 target Hispanic teens, 1 targets Hispanic and African American teens and 1 targets mixed ethnicities. A pamphlet was developed that targeted providers.

Activity 4: Provide funding to community-based initiatives to promote abstinence from sexual activity through strategies that include abstinence education, mentoring, counseling and/or adult-supervised activities.

Update: The Abstinence Education Program had 32 contractors in FY 02. The state program continued a media campaign with TV spots targeting parents, continued a web page targeting children and began developing an educational video and handbook to help parents talk to their children about sex and abstinence. About 29,972 television spots were delivered in 13 TV and 18 radio markets. The website receives an average of 900 hits per month. In FY02, the Abstinence Program served an estimated 392,801 clients that included adolescents, parents/caretakers, teachers, health care providers and community leaders.

Activity 5: Provide traffic-safety presentations to children ages 3-14 regarding bicycle and car seat safety, particularly among African American families.

Update: 7 train-the trainer 32-Hour Child Passenger Safety (CPS) workshops were conducted throughout the state. 184 participants were trained as CPS technicians.

Activity 6: Develop a state plan to prevent and control obesity through nutrition and physical activity interventions. Update: Over 200 representatives from local, state and federal government agencies, professional and industry organizations, and non-profits attended the obesity stakeholder's one day meeting held on August 8, 2002. The meeting's purpose was to enlist the comments of state-level partners regarding the draft of the Strategic Plan for Obesity Prevention in Texas. Of 260 partner invites, 101 attended a half-day meeting where a brief presentation of the plan was given. The meeting included a general lecture section on a variety of pertinent obesity topics as well as workgroups providing feedback and input on the Obesity Task Force's draft goals. The feedback was compiled and presented to the Obesity Task Force members, which the Task Force then used to develop an overall state plan. The state plan to prevent and control obesity through nutrition and physical interventions was completed in mid-December 2002. The plan, developed over the 18 months by a statewide task force assembled by the Texas Department of Health (TDH), calls for increasing awareness of obesity as a public health threat; mobilizing families, schools and communities to create opportunities for healthy lifestyles; promoting policies and environmental changes that support healthful eating habits and physical activity; and monitoring obesity rates and related behaviors and health conditions.

Activity 7: Contract with the University of Texas in Austin to help conduct social marketing research and design appropriate interventions that address proper nutrition and physical activity in the target population. Update: A contract with the University of Texas in Austin to help conduct social marketing research and design nutrition and physical activity interventions was successfully written and executed during FY02. Social marketing research using focus groups and the formation of intervention school coalitions was also completed. In September 2002 nutrition and physical activity interventions were implemented with the implementation ongoing. Nutrition interventions included cafeteria promotions, classroom activities and school lunch menu modifications. Participating intervention schools were Copperfield Elementary (Public Health Region 7 – Pflugerville), Berkman Elementary (Public Health Region 7 – Round Rock), and Tom Green Elementary (Public Health Region 7 – Hays County). These schools were selected to represent the ethnic diversity of Texas, with 45 percent of participants being Hispanic, twenty-eight percent Anglo and 13 percent African American. Teachers received training on ways to incorporate more physical activity into their existing lessons, for example active math and active reading. Each school's coalition tailored each of the physical activity interventions based upon their physical activity needs, resulting in differing interventions at each school. For example, an assessment of school grounds at one school (Berkman Elementary) revealed that a schoolyard retainer fence was not high enough to prevent balls from being thrown out of the schoolyard. Part of the physical activity intervention for Berkman Elementary was to extend the fence to a right that prevents balls from going off school grounds and interrupting the physical activity. . At the other two schools (Copperfied and Tom Green) running/walking tracks were created. All three schools, based upon their school's coalition

identification of school needs, also received other equipment including jump ropes, basketballs, and larger basketball hoops. The targeted completion date for each intervention is May 2003. Post evaluations for intervention and control schools will include measurements of height and weight of students and determination of body mass index (BMI). A survey on nutrition and physical activity will be administered to the students at both intervention and control schools for comparison purposes. Results will be reported in the FY 2003 annual report.

Activity 8: Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well child check ups for age according to the periodicity schedule. Update: In FY 2002, teams of Title V staff monitor Title V contractors compliance with a number of criteria. One of those requirements is that 90% of children be current on well-child check ups for age according to the periodicity schedule. For FY 2002, 21 of the 22 contractors who provide child health services were documented as having a system in place to ensure that 90% of children would be current on well-child checkups.

b. Current Activities (FY 03):

Activity 1: Provide training on youth risk reduction and youth health promotion to health care and education professionals at regional Education Service Centers.

Update: Educational Service Center staff (ESC) provided training on a number of different topics such as; tobacco abuse, substance abuse (drug and alcohol), teen pregnancy, STD's, motor vehicle deaths/injuries, homicide, suicide, and others) for the first two quarters of FY 2003. Third quarter data is pending analysis. For the first two quarters of FY 2003, 496 workshops were conducted with a total of 11, 501 participants completing a total of 58, 774.25 clock hours of training. Participants completed evaluations. The average for the evaluations was 4.8 on a scale of 1 through 5 (with 5 representing excellent). Third quarter data is pending analysis.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Update: The Abstinence Education Program has served a total of 228,656 clients to date in FY 03 and has a total of 33 contractors located in ten of TDH's 11 PHRs. Please see the plan for the coming year to identify ongoing activities.

c. Plan for Coming Year (FY 04):

Activity 1: Provide training on youth risk reduction and youth health promotion to health care and educational professionals at regional Education Service Centers.

Output Measure: Number of workshops provided, number of participants and clock hours of training.

Monitoring: Track scheduled presentation on a quarterly basis.

Evaluation: Document and review local evaluations at each local ESC for overall satisfaction with curriculum provided.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities. (Same as Activity #2, National Performance Measure 8 – birth rate).

Output Measure: Number of unduplicated clients served including: teens/children, parents and health providers that are provided with abstinence education information. Document the age, ethnicity, and service delivery area served for unduplicated clients.

Monitoring: Review abstinence contractor reports of the number of unduplicated clients and the areas served on a monthly basis. Provide technical assistance to improve overall contractor performance.

Evaluation: Determine contractor goals for the projected number of clients to be served, and review contractor performance from monthly reports.

State Performance Measure 03: Percent of infants and children (aged 0-12) who will thrive.

Last Year's Accomplishments (FY 02):

Activity 1: The Take Time for Kids Program will contract with Texas A&M Extension Service (TAES) to continue conducting the parent education train-the-trainer workshops for professionals, daycare staff, and community leaders. The purpose is to increase parents' knowledge and skills about the importance of well-child check-ups, immunizations, and other children's health issues.

Update: Of the 11 workshops planned, the TAES conducted 9 parent education train-the trainer workshops for professionals, childcare staff, and community leaders throughout FY 2002. Participants included representatives from public health, WIC, community social service agencies, early childhood educators, school nurses and community coalitions focusing on young children. A total of

230 trainers were trained and 250 parents in 11 counties were educated with the materials presented. An evaluation, compiled by the Texas A&M Extension Service and Title V, and administered at the conclusion of the workshop, showed an overall satisfaction with workshop presenters and workshop materials. Between 41.6 and 61% of parent educators indicated they used the workshop materials and information. Texas A&M and Title V developed a phone survey, designed for use two (2) months after parents attended the workshop to measure parent knowledge, skills and attitudes. Though only 85 successful phone contacts were made due to wrong or disconnected numbers, moves, etc., over half of those contacted reported that there were significant increases in parents reading to their children, parents complimenting their children, and parents encouraging their children. Parents also reported significant increases in parents communicating behavioral expectations of their children and in praising their children. Persons contacted also reported that there were significant decreases in parents feeling helpless in parenting their child and spanking and yelling at their child. Parents indicated they still had questions concerning how to be a better parent, how to help their children do well and be successful and about issues facing older children (e.g., dating, birth control and boy-girl relationships) that emphasized the need for continuing education. Information regarding parent feedback was included in Texas A&M's evaluation report submitted to TDH and was utilized in future curriculum planning.

Activity 2: The Take Time for Kids program will develop and distribute a parent education magazine for parents of Medicaid children birth thru 12 months of age. The magazine will inform parents of medical check-ups and immunizations along with other age appropriate information on nutrition, child development, and basic care of the child. Update: During the first six months of FY 2002 there were approximately 215,000 English language and 90,00 Spanish language issues of the Take Time for Kids magazine distributed. Due to funding issues and focus on other priorities, publication and distribution of the magazine was discontinued and no copies of the magazines were distributed during the remainder of the year.

Activity 3: Encourage Title V contractors and other providers of preventive child and adolescent services to provide preventive health care according to TDH Guidelines, American Academy of Pediatrics or Bright Futures guidelines. Current Title V policy requires 90 percent of children be current on well child check ups for age according to the periodicity schedule.

Update: During the year, teams of TDH staff monitor Title V contractors compliance with a number of criteria. One of those requirements is that 90 percent of children be current on well child check ups for age according to the periodicity schedule. For FY 2002, 21 of the 22 contractors who provide child health services were documented as having a system in place to ensure that 90% of children would be current on well-child checkups.

Activity 4: Expand parenting education opportunities regarding car seat safety for children birth thru 4 years of age through the Take Time for Kids Parent Education Workshops, particularly among African American families.

Update: Seven train-the trainer 32-Hour Child Passenger Safety (CPS) workshops were conducted in these locations: El Paso (Public Health Region 10), Ft. Worth (Public Health Region 2/3), Houston (Public Health Region 5S/6), Wichita Falls (Public Health Region 2/3), Southlake, Lubbock (Public Health Region 1), Austin (Public Health Region 7) and Amarillo (Public Health Region 1) with 184 participants trained to become CPS Technicians. All classes received overall evaluations averaging above 4, with 5 being the highest score. Each of these CPS technicians will educate parents in their community about the safe transport of their children and the correct way to install their child's safety seat. Information on age, race and ethnicity is currently not collected by the program.

Activity 5: Provide traffic-safety presentations to children ages 3-14 regarding bicycle and car seat safety, particularly among African American families.

Update: A total of 154 traffic-safety presentations were conducted with 2,800 children and parents receiving information and instruction regarding car seat safety. Age specific demographics, as well as race and ethnicity are currently not collected by the program. Verbal pre- and post-tests for children were conducted and pre- and post-written tests for adults were conducted. Test results indicated an increase in safety seat knowledge. Parents and children listened intently and participated actively in the presentations.

Activity 6: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from ages birth to about age 6.

Update: A total of 20,291 safety seats were distributed to low-income families in Texas during FY 2002. The Emergency Medical Services system distributed 17,010 seats in ninety-three (93) locations and 3,281 were distributed through the seventy-three (73) Traffic Safety Distribution programs. The age of safety seat recipients is currently not collected. Parents or caregivers calling the Traffic Safety 1-800 number to inquire about a safety seat are directed to a distribution program near them. Each parent receiving a seat was educated about the safe transport of their child and how to install the seat correctly. This program was very successful and resulted in many families in Texas receiving safety seats and related education as a result. One child that we know of involved in a crash was saved because of a safety seat provided by this project.

Activity 7: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors in youth.

Update: During the initial process of planning for this particular performance measure staff were dedicated for the "Youth Health Initiative," however, due to funding shortfalls and a reduction in funding specific to this program, this measure was not evaluated, nor the activities completed. The program supporting this particular measure was disbanded, however some of the learned philosophies relative to youth development and resiliency are incorporated in various department activities and the day to day work of those involved in the discontinued initiative.

Activity 8: Take Time for Kids program will fund a pilot site (Dallas) to decrease Sudden Infant Death Syndrome (SIDS) from 1.78 per 1000 births to .77 per 1,000 births among African-American children in the city of Dallas by 2004. The pilot program will ensure access to SIDS prevention information, intervention, education, and other resources by establishing a coordinated and comprehensive system to educate African-American caregivers of children under one year of age. Update: The contractor selected as the pilot site was the Dallas City Health Department. During the first six months of FY 2002, surveys for child care providers and other health professionals were developed and the process for focus groups was developed. During the 3rd quarter of FY 2002, 26 childcare providers, all of whom are predominately African-American, were interviewed as to correct infant sleep positioning practices.

Approximately 100 "Preventive Counseling Services" surveys (used to evaluate the counseling habits of health care professionals) were administered to WIC clinics, child health clinics, and county clinics. This survey assisted with what messages the professionals are giving about sleep position and prevention of SIDS. The planned focus groups were eliminated from the plan due to funding issues and focus on other agency priorities. At the end of FY 2002, over 3,000 media materials had been distributed, over 50 caregivers educated and 200 parents educated (which equated to 60% of targeted African-American population) in certain zip codes in Dallas. Demographics and findings collected from these efforts included:

- parents ranging in age from 15 to 29;
- 39 (or 19.5%) of the parents had less than a high school education;
- birth weights of children (in targeted child care centers) ranged from 4.31 pounds to 9 pounds;
- 80% of child care providers had African-American children in child care centers;
- 59% of parents shared their bed with an infant;
- 70% of parents smoked around the infants;
- 11% of parents did not relate the prevention of SIDS to placing a child to sleep on his back; and
- 45% of childcare workers did relate the prevention of SIDS to placing a child to sleep on his back.

After the first year of the three (3) year plan, the contract was de-funded due to funding issues and focus on other agency priorities.

Activity 9: Take Time for Kids program will fund a pilot site to decrease incidence of child abuse by 3% by FY 2004. The pilot site will increase parent/caregiver knowledge of normal infant development, Shaken Baby Syndrome (SBS), importance of reading to children, infant massage, and community support and resources. Update: Williamson County Health Department (Public Health Region 7) was selected and funded as the pilot site for this activity. Their activities were designed to increase parent/caregiver knowledge of normal infant development, Shaken Baby Syndrome (SBS), the importance of reading to children, the benefit of infant massage and to provide community support and resources. The target audience for this pilot consisted of parents in WIC, public health staff and hospital staff in the community. During the first and second quarters of FY 2002 training protocols were developed as well as a pre and post-test evaluation. During the third quarter public health staff were trained on how to educate WIC and other clients on the prevention of Shaken Baby Syndrome and the benefits of infant massage for the purpose of preventing child abuse. Brochures were developed and used during the education progress. Information included messages about nurturing during infancy through infant massage, how to manage crying infants, and information for parents on how to help themselves deal with stress. By the end of FY 2002, over 12,000 brochures were distributed within the community to hospitals, schools, churches and other community agencies. Ten (10) public health staff were trained; 70 parents were educated; 31 follow-up contacts with parents were conducted; and four (4) community presentations (including hospital staff) were made. The Shaken Baby Syndrome/child development and infant massage workgroup was developed for community hospital use but not evaluated. In the WIC clinics, there was a 30% reported change of parents in knowledge, skills and attitude in regards to management of crying, how to help themselves as parents and in nurturing techniques such as infant massage. After the first year of this three (3) year plan, due to funding issues and focus on other agency priorities, this funding for this activity was not continued.

b. Current Activities (FY 03):

Activity 1: The Take Time for Kids Program will contract with Texas A&M Extension Service to continue conducting the parent education train-the-trainer workshops for professionals, daycare staff, and community leaders. Training sessions are held to improve parents overall knowledge in preventive health areas.

Update: To date 6 trainings have been held as well as a planning session to form community coalitions in two other areas of the state.

Activity 2: Provide traffic-safety presentations to children ages 0-8 regarding bicycle and car seat safety.

Update: Safe Riders does not have a bike helmet program, but the program does order low cost helmets through SAFE KIDS when requested by community groups. Low cost bike helmets were ordered for four agencies between November 2002 and April 2003. A total of 340 helmets were ordered.

Since September 2002, the Safe Riders Traffic Safety Program provided 50 child passenger safety presentation to a total of 969 children/adults. Records of attendance (including number of participants) are maintained in central office.

Activity 3: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.

Update: The state safety seat distribution program ordered a total of 11, 064 seats on May 16, 2003. The seats were distributed to 113 safety seat distribution programs. These seats are provided from the Texas Department of Transportation federal pass through funds.

As of May 2003, nine (9) distribution trainings had been held and the number of persons receiving training was 97.

Activity 4: Promote, facilitate, and disseminate the philosophy, methods and model strategies that promote the development of resiliency and other protective factors among children aged 15-19 years.

Update: The Youth Health Initiative was eliminated due to funding issues. There was a significant reduction in Title V funding to the Educational Service Center (ESC) contractors (i.e., the School Health Network) Measures relative to this activity were not include in the contract with the ESCs for FY 2003.

c. Plan for Coming Year (FY 04):

Activity 1: Develop a statewide Early Childhood System in conjunction with internal and external stakeholders. Recommendations will be included in a comprehensive state plan and presented to the Associateship of Family Health.

Output Measure: Number and types of recommendations to be included in the comprehensive state plan.

Monitoring: Track the process of plan and recommendations development.

Evaluation: Assess the planning process for effectiveness of the development of an early childhood system.

Activity 2: Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety. (Same as Activity 1, National Performance Measure 10 – motor vehicle crashes)

Output Measure: Number of presentations conducted statewide; number of children/adults attending each presentation.

Monitoring: Track progress of presentations (per calendar) as relayed in monthly report.

Evaluation: Conduct a verbal pre- and post presentation test of children to ascertain increase in knowledge.

Activity 3: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8. (Same as Activity 2, National Performance Measure 10 – motor vehicle crashes)

Output Measure: Number of seats distributed statewide.

Monitoring: Track development and progress of distribution program.

Evaluation: Assess the effectiveness of the project by reviewing data from the Texas Transportation Institute on statewide child restraint usage in comparable areas.

Activity 4: In the continued effort to create a statewide suicide prevention plan, work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state. (Same as Activity 1, National Performance Measure 16 – teen suicide)

Output Measure: Statewide prevention plan developed; grant funding secured from public and private entities to implement components of the state plan.

Monitoring: Track the progress of the initiative via grants secured and state and local government support.

Evaluation: Assess the overall changes in the suicide rates after activities/plan has been implemented and the level increased awareness in the state of the issue of suicide prevention.

State Performance Measure 04: Ratio of Black low birth weight rate to White low birth weight rate.

a. Last Year's Accomplishments (FY 02):

No FY 02 Activities are available as this did not become a State Performance Measure until FY 03

b. Current Activities (FY 03):

Activity 1: Promote smoking cessation to African-American women ages 13-44, including pregnant women in TDH Regions 2, 3, 4, 5, 6 by informing providers about smoking cessation programs and distributing smoking cessation counseling.

Update: There were 358 unduplicated calls made to the Great Start Smoking Cessation Line (specifically designed for pregnant callers) by women ages 13-44 in FY 03. The Siebel automated system recorded that 58 callers were pregnant, 4 were not pregnant, 296 listed as unknowns (due to an application error), 44 were Anglo, 12 African American, 6 Hispanic and 5 as others. There were 1,444 unduplicated calls made to the Quitline Smoking Cessation Line by women ages 13-44 during the first three quarters of FY 03. 44 callers reported to the Siebel system that they were pregnant, 1,343 were not pregnant, 57 had unknown status, 868 reported reported that they were Anglo, 262 African American, 140 Hispanic and 42 as others. The Quitline Smoking Cessation Line is designed for all women. When it is determined a caller is pregnant, the caller is referred automatically to the Great Start Smoking Cessation Line.

Activity 2: Develop and provide a 2-hour training session with CEUs and web-based educational materials for providers on low birth weight and prematurity. Topics to be included are: overview of the problem; relevant statistics; personal, social and economic impact low birth weight births and strategies to address the problem, including: first trimester identification of risk, smoking cessation and impact of second-hand smoke, treatment of bacterial vaginosis, access to care issues, focusing on African American women and families.

Update: Title V Perinatal staff worked with the Shaken Baby Alliance, other stakeholders, and health care and public health professionals to develop an eight hour train-the-trainer curriculum entitled the "Infant Mortality Prevention Education Program (IMPEP). The curriculum includes 4 sessions: Perinatal Issues, Sudden Infant Death Syndrome, Accidents and Abuse and Neglect. The training includes PowerPoint presentations, an in-depth support curriculum and many references and handouts. Development of the IMPEP began in the fourth quarter of FY 02. IMPEP training and curriculum development was completed in the first quarter of FY 03. Training began in January 2003 and has been conducted in eight of the 11 public health regions. The final three training sessions are scheduled for Summer 03. A Title V perinatal staff person has presented the Perinatal Issues section at all but one of the IMPEP trainings. The Perinatal website is currently in development. The full IMPEP curriculum will be

available on the website as soon as the website is operation. Training is being presented to a wide variety of individuals, ranging from health care providers, representatives of social service organization, state and local agency employees, and law enforcement personnel.

This is a new activity. Please see the plan for the coming year to identify ongoing activities.

c. Plan for Coming Year (FY 04):

Activity 1: Promote smoking cessation to African-American women ages 13-44, including pregnant women in TDH Public Health Regions 5 (Tyler) and 6 (Houston) by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.

Output Measure: Number of providers contacted; numbers and type of smoking cessation materials distributed; number of calls made to the Quit line by non-pregnant women ages 13-44; number of calls to Quitline by pregnant women.

Monitoring: Posting of the educational materials on the web-site completed; number of training sessions provided, number of participants completing training; track number of calls to the Quit line.

Evaluation: Assess changes in low birth weight births in TDH Public Health Regions 5s and 6.

State Performance Measure 05: The prevalence of childhood obesity.

a. Last Year's Accomplishments (FY 02):

Activity 1: Develop a state plan to prevent and control obesity through nutrition and physical activity interventions.

Update: Over 200 representatives from local, state and federal government agencies, professional and industry organizations, and non-profits held an obesity stakeholder's meeting held in August 02. The meeting's purpose was to enlist the comments of state-level partners regarding the draft of the Strategic Plan for Obesity Prevention in Texas. 101 attended a meeting where a brief presentation of the plan was given as well as a general lecture section on a variety of pertinent obesity topics as well as workgroups providing feedback and input on the Obesity Task Force's draft goals. The feedback was compiled and presented to the Obesity Task Force members, which the Task Force then used to develop an overall state plan. In December 02, the plan to prevent and control obesity through nutrition and physical interventions was completed. The plan calls for increasing awareness of obesity as a public health threat; mobilizing families, schools and communities to create opportunities for healthy lifestyles;

promoting policies and environmental changes that support healthful eating habits and physical activity; and monitoring obesity rates and related behaviors and conditions.

Activity 2: Contract with the University of Texas in Austin to help conduct a social marketing research and design appropriate interventions that address proper nutrition and physical activity in the target population. Update: A contract with the University of Texas in Austin to help conduct social marketing research and design nutrition and physical activity interventions was successfully written and executed during FY02. Social marketing research using focus groups and the formation of intervention school coalitions was also completed. In September 2002 nutrition and physical activity interventions were implemented with the implementation continuing into FY03. Nutrition interventions included cafeteria promotions, classroom activities and school lunch menu modifications. Participating intervention schools were Copperfield Elementary (Public Health Region 7 – Pflugerville), Berkman Elementary (Public Health Region 7 – Round Rock), and Tom Green Elementary (Public Health Region 7 – Hays County). These schools were selected to represent the ethnic diversity of Texas, with 45 percent of participants being Hispanic, 28 percent Anglo and 13 percent African American. Teachers received training on ways to incorporate more physical activity into their existing lesions, for example active math and active reading. Each school's coalition tailored each of the physical activity interventions based upon their physical activity needs, resulting in differing interventions at each school. For example, an assessment of school grounds at one school (Berkman Elementary) revealed that a schoolyard retainer fence was not high enough to prevent balls from being thrown out of the schoolyard. Part of the physical activity intervention for Berkman Elementary was to extend the fence to a right that prevents balls from going off school grounds and interrupting the physical activity. At the other two schools (Copperfied and Tom Green) running/walking tracks were created. All three schools, based upon their school's coalition identification of school needs, also received other equipment including jump ropes, basketballs, and larger basketball hoops. The targeted completion date for each intervention is May 2003. Post evaluations for intervention and control schools will include measurements of height and weight of students and determination of body mass index (BMI). A survey on nutrition and physical activity will be administered to the students at both intervention and control schools for comparison purposes. Results will be reported in the FY 2003 annual report.

b. Current Activities (FY 03):

Activity 1: Continue, 1) the development of the state plan to prevent and control obesity, and 2) the development of a marketing plan to promote the adoption of the state plan into internal and external organizations' action strategies.

Update: The Strategic Plan was released during the 2-day Promoting Healthy Weight in Texas Conference that took place in San Antonio in February 2003. Copies of the Strategic Plan for the Prevention of Obesity in Texas were distributed to all conference attendees including physicians, nurses, dietitians, health educators, school professionals, and community leaders. The four goals focused on eliminating obesity center around increasing awareness of the problem of obesity, monitoring and disseminating data, creating collaborations that create opportunities to make lifestyle choices that support good nutrition and physical activity and policy and environment changes that support healthful eating habits and physical activity. A statewide steering committee to begin and monitor implementation of the plan is currently being formed.

Ten communities received competitive mini-grants of $4, 999 to develop or improve a community trail, promote it, and evaluate the trail's use. This project addresses goal 3 of the state plan that says, “promote policies and environmental changes that support healthful eating habits and physical activity.”

To date 1 community organization, the Houston-Harris County Youth Nutrition and Fitness Initiative is using the state plan for nutrition and physical interventions. The goal of the efforts in that community are to treat and prevent children and adolescents from becoming overweight by developing a strategic, comprehensive, community-based program. This plan (available at http://slehc.org/slehc) will be piloted in the East End community of inner city Houston. The East End community is medically underserved, low income and is predominantly Hispanic in its population.

Activity 2: Contract with the University of Texas in Austin to help implement health promotion activities at intervention schools (i.e., taste tests for new-lite menu items, health fairs, field days, health fairs, parent/student nights) to address proper nutrition and physical activity in the target population.

Update: The contract with the University of Texas – Austin was approved and interventions completed. The social marketing and physical activity interventions have been completed. It is important to note that the effects of the physical activity interventions in the three intervention schools are ongoing. Interventions included environmental changes to schools (i.e., building running tracks, purchasing basketballs and jump ropes, etc) and implementing changes to classroom lessons to make them more active. Though the changes have been made and the teachers trained, the effects are ongoing and still being evaluated. The evaluation stage of this activity is ongoing and not yet complete.

c. Plan for Coming Year (FY 04):

Activity 1: The Texas State Strategic Health Partnership Workgroup will expand the “Strategic Plan for the Prevention of Obesity in Texas” to be a comprehensive state plan. The plan will address 1) obesity prevention and control including

caloric expenditure and intake; 2) increased consumption of fruits and vegetables; 3) increased physical activity; 4) reduced television time; and 5) increased breastfeeding.

Output Measure: State plan completed.

Monitoring: Follow up progress on development of plan.

Evaluation: Assess the likelihood of state plan components to be implemented and the likelihood of the desired outcomes to be achieved.

Activity 2: Contract with the University of North Texas Health Science Center (UNTHSC) to conduct social marketing research to develop messages to use with the implementation of the "Strategic Plan for the Prevention of Obesity in Texas."

Output Measure: Contract with UNTHSC developed and executed; numbers and types of concepts and messages tested.

Monitoring: Track progress on the completion of activities; keep a record of events and the number/location of participants where messages were tested.

Evaluation: Conduct qualitative research (e.g., focus groups and/or in-depth interviews conducted with target audiences) and a report of findings.

State Performance Measure 06: Incidence of carious lesions among school children in Texas.

a. Last Year's Accomplishments (FY 02):

Activity 1: Conduct statewide survey of caries prevalence among 3rd to 7th grades children.

Update: Public Health Regional Dental Directors completed surveys at multiple locations within their regions. Oral examinations were provided for 31,566 children participating in the school free-lunch program. The number of schools is not tracked separately. Active caries were present in 11,677 (or 37%) of the children examined.

Activity 2: Plan and implement teledentistry pilot study.

Update: The Health and Human Services Commission, with representation from the Texas Department of Health's Oral Health Division, formed a committee to address a legislative mandate concerning teledentistry. While no funding was available for the pilot project, a small teledentistry pilotbegan in FY 02 in Dr. Lars Folkes' practice in South Texas. Pittsburg Independent School district has set up

a dental clinic in their elementary school and are using teledentisty as part of their model. They also are pursuing plans to hire a school hygienist. Evaluation and reporting on this pilot and tangential activities (i.e., Pittsburg ISD activities) is ongoing.

b. Current Activities (FY 03):

Activity 1: Conduct statewide survey of caries prevalence among school children in Texas.

Update: Of 17,691 school children examined, 5560 or 31.4% exhibited active caries.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available.

Update: The Texas Fluoridation Project provides assistance and monitors public water systems that adjust the parts-per-million (PPM) of fluoride in the drinking water. The project provides services to meet the national objectives of Healthy People 2010 to reduce dental caries. In the first three months of FY 03, the City of Blanco and the Brown County Water Improvement District in Brownwood, Texas upgraded their water fluoridation systems. Fifteen million Texans or 68% of the population, currently receive the optimal amounts of fluoride in their drinking water (between .8 and 1.2%). This amounts to 639 systems, 216 of which adjust their fluoride level.

c. Plan for Coming Year (FY 04):

Activity 1: Conduct statewide survey of caries prevalence among school children in Texas.

Output Measure: Number of school-aged children examined.

Monitoring: Track standardization and calibration for survey methodology; track progress on collection, compilation and analysis of data.

Evaluation: Review survey results and profile geographic areas and other indicators with high occurrence of dental caries.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available

Output Measure: Number of fluoridated community systems maintained and number of upgrades to existing fluoridation systems.

Monitoring: Track location of each system maintained or upgrade to system and number of individuals served by fluoridation system.

Evaluation: Measure the increase in systems and populations served.

State Performance Measure 07: Percent of female clients suspected of being victims of relationship violence.

a. Last Year's Accomplishments (FY 02):

Activity 1: Distribute the program policy and guidance on family violence for Title V and other interested health care providers and seek feedback on the usefulness of the model policy and procedures for victims of family violence/relationship abuse.

Update: One copy of the program policy and guidance on family violence for Title V and other interested health care providers were distributed. Brochures about male teen dating violence, female teen dating violence and posters about male dating violence and female dating violence were distributed to a wide variety of professionals for use in their office or clinic settings and for further dissemination to consumers. Due to funding issues and/or other priority initiatives a questionnaire to assess the usefulness and effectiveness of the policy manual was not developed during FY 2002.

Activity 2: Through the web, provide accessible abuse prevention and youth development training to Title V providers, TDH regional offices, and other interested health care providers.

Update: A website to provide accessible abuse prevention and youth development training materials and modules to Title V providers, TDH regional offices and other interested health care providers remained in development during FY 2002. This new site, "Helping Teens Prevent Sexual Coercion," was launched on January 1, 2003. With the assistance of the Family Planning Program, the Office of Special Projects maintains and updates the web site. The interactive web site offers CEUs for nurses, social workers and Licensed Professional Counselors. It features frequent updates as to laws, grant requirements and the lastest adolescent counseling information. The web based learning module also contains an evaluation component. The results will provide the information for continuous improvements as well as provide an opportunity to measure the reliability of the module.

Activity 3: Coordinate with TDH regional offices and the Take Time for Kids Program (TTFK) to provide support for community/local awareness campaigns targeting high risk population groups for abuse.

Update: Due to a focus on other priorities and a lack of funding, the Take Time for Kids Program was in the process of being disassembled in FY 2002. No support was provided to community/local awareness campaigns and no abuse prevention materials were developed and/or distributed in FY 2002.

b. Current Activities (FY 03):

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Update: Copies of the program policy were distributed to two providers. In addition, to date in FY 2003, the following education materials (with number distributed) have been distributed: Male Teen Dating Violence Brochures (830), Male Teen Dating Violence posters (11), Female Teen Dating Violence Brochures (830) and Female Teen Dating Violence Posters (11). To date in FY 2003, the questionnaire to assess the usefulness of the materials has not been developed.

Activity 2: Through the program website, provide accessible abuse prevention and youth development training to Title V providers, TDH regional offices, and other interested health care providers.

Update: One module, "Caring for the Adolescent Patient: Preventing Sexual Coercion," was developed during FY 2003 and has been made available on a website currently only accessible to family planning providers. CEUs for the module are available. Currently no counter exists on the website, but program staff have received 24 feedback forms from individuals.

Activity 3: Apply to the Centers for Disease Control (CDC) for a one-year funding grant to support the development of a strategic plan to prevent domestic violence.

Update: In September 2002, the Bureau of Women's Health received a $50,000 grant to develop a strategic plan for Texas to prevent violence against women. Texas' plan, which will be completed by September 30, will focus on primary prevention. An advisory committee representing key stakeholders from around the state met in April and May 2003. Meetings are scheduled through August 30th on the last Friday of each month.

c. Plan for Coming Year (FY 04):

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Output Measure: Number and type of materials distributed; number of entities receiving materials and number of requests for information received.

Monitoring: Track distribution of materials.

Evaluation: Assess the usefulness and effectiveness of the materials by enclosing a questionnaire with the educational materials to be returned to the program at a later time.

Activity 2: Through the program website, continue providing accessible abuse prevention and youth development training to Title V providers, TDH regional offices, and other interested parties.

Output Measure: Training modules developed and accessible to interested parties on the TDH website; number of hits to the training module website; number of participants completing the training by type and region; and number of requests for technical assistance received.

Monitoring: Track the number of hits to the program website on the TDH web page.

Evaluation: Assess the usefulness and effectiveness of the training by evaluating feedback forms from the training website.

Activity 3: Implement the statewide strategic plan to prevent violence against women.

Output Measure: Quarterly reports of Violence Against Women Plan (VWAP) strategic plan implementation activities.

Monitoring: Maintain a log of meetings with the Texas Family Violence Council, TDH Injury Prevention Program and the TDH Center for Health Training; document minutes from meetings; keep track of the major steps of the plan implementation.

Evaluation: Evaluate implementation of the strategic plan based on the priority needs derived from the needs assessment conducted in Spring 2003.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet: Up to 10 major activities can be listed for each of the State Performance Measures and these activities should be identified by the level of the pyramid. Specific activities may reflect different levels of the pyramid than the corresponding performance measure. To complete Figure 4b, click on the hyperlink above.

Figure 4b is part of Appendix E.

E. OTHER PROGRAM ACTIVITIES

Toll-Free Hotline

The Family Health Services (previously called "BabyLove") is the statewide toll-free line that provides information on programs in the Associateship for Family Health. In addition, this line provides information and referral (I & R) on public/private providers of health and human services that complement the health services provided by TDH. The target populations for the toll-free line include: children from birth to 21, CSHCN and their families, women, pregnant women, parents, child caregivers, school health providers, family health care providers, community leaders, and outreach workers.

Associateship for Family Health programs listing the Family Health Services number include:

Child Wellness Programs

Take Time For Kids Program

Texas Health Steps (formerly EPSDT)

Children With Special Health Care Needs (Chronically Ill and Disabled Children's Program)

Newborn Screening

Program for Amplification for Children of Texas (PACT)

School Health

Nutrition Services for Women, Infants and Children (WIC)

Family Planning

Prenatal Care

Oral Health Services

Related services on which information is generated include:

Medicaid

Medical Transportation

Food Stamps

Temporary Assistance for Needy Families (TANF)

Early Childhood Intervention

Immunizations

Parenting classes

Service providers for the blind and visually impaired (Texas Commission for the Blind)

Service providers for substance abuse (Texas Commission on Alcohol and Drug Abuse)

Service providers for mental illness and mental retardation services (Texas Department of Mental Health and Mental Retardation)

Texas Special Education hotline (includes information on children with disabilities, section 504 of the Rehabilitation Act)

Texas Rehabilitation Commission (job training for persons with disabilities)

Referral to licensed child-care facilities

Information on resources for children who are medically fragile

During FY99, the Associateship convened an Information and Referral Workgroup to examine to current and future needs of the Family Health Services hotline. As a result, TDH updated the BabyLove database, purchased new I & R software, obtained I& R specialist training and certification for the Family Health Services Manager, and began a process of quality improvement around program data collection, monitoring and evaluation.

/2004/The hotline received 6,425 calls in FY 02 and to date in FY 03 has received 6,160 calls. **//2004//**

F. TECHNICAL ASSISTANCE

/2004/ Like many states, Texas' economy, population and health needs of that population, continue to evolve. Increasingly the governmental infrastructures that support them are being called upon to work more effectively and efficiently with limited and often decreasing resources. Consideration and fulfillment of Texas' requests for technical assistance, as illustrated on Form 15, will continue and/or enhance existing efforts designed to meet the changes in this dynamic environment, specifically in the area of women's health.

Form 15 (*See Forms Section*) provides a preliminary idea of some of the major issues that Texas has identified to receive consultation help and effort during the coming year and for which Texas' requests technical assistance.

Item 1 on Form 15 specifically relates to National Performance Measure 15 - the percent of very low birth weight infants among all live births. Texas requests assistance in identifying low-cost strategies/best practices that other states (or entities) have used to address this issue. Title V could then offer Texas' public health regions and local health departments and/or other entities strategies that could be easily adapted to meet Texas' needs. Technical assistance in identifying the effective and proven strategies employed by other states or entities would be helpful and eventually would be adapted for use in Texas communities.

Item 2 on Form 15 relates to National Performance Measure 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Again Texas requests assistance in identifying (and perhaps modifying for use in Texas) proven low-cost strategies and best practices in this area used by other states or other entities focused on the same populations. Adaptation of some of those identified strategies for use in Texas would facilitate progress toward increasing the percent of infants born to pregnant women receiving prenatal care.

Item 3 on Form 15 does not relate to any specific measure, but has implications for all of those focused on women's health issues. This technical assistance request seeks expertise in the area of assessment of health status in women. Specifically Texas asks for assistance in developing, implementing and analyzing the results of a statewide assessment of the health status of women of childbearing age. This assessment would then be conducted at a regular interval (i.e., every 5 years). Results of the assessment would be used by internal and external stakeholder and policy decision makers in meeting the needs of this population; as well as in strategic planning. Currently many stakeholder do not have a complete understanding of how various data pieces interrelate and how such data, when viewed comprehensively, often presents a full assessment of the status of women in the state and ultimately how that assessment can in turn impact perinatal outcomes.

Item 4 on Form 15 again does not relate to a specific measure, but definitely would have an impact on many maternal and child health programs at TDH. This request repeats a request made last year in the area of social marketing. Specifically Texas Title V requests that a traveling training team from the Annual Social Marketing Conference travel to Texas to present this training for the maternal and child health program staff in Texas as well as interested stakeholders. Effective use of social marketing in the areas of outreach to common populations will have an impact on the health status of our targeted populations. Bringing this renowned training to Texas will facilitate enhanced

and common understandings about the benefits and used of social marketing specifically within the framework of public health. Information and collaborations formed as a result of the training and the enhanced knowledge may help both TDH and its stakeholders in leveraging limited funds and enhancing existing and fostering new collaborations.

Item 5 on Form 15 relates to all the CSHCN national and state performance measures. Specifically Texas CSHCN Program requests technical assistance in identifying and implementing best-practices and low-cost effective strategies that other states use to address the needs of CSHCN given ongoing changes and limitations in both state CHIP and Medicaid Programs, as well as best practices in other states on projecting program expenditures and remaining within budget while adjusting to fluctuating health care costs. Receipt of this technical assistance will help Texas, and likely other states, in managing many facets of CSHCN programs in very dynamic and resource challenged environments. **//2004//**

V. BUDGET NARRATIVES

A. EXPENDITURES

FY 04 Application Update

Forms 3, 4, and 5 show variations in the expenditure amounts that could be explained by the budget realignment conducted for FY 02 and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 02. The expenditure level decreased from $107,287,294 in FY 01 to $101,362,842 in FY 02, representing about a $5.92 million or a 5.5% variation. This is justified, since the total Title V budget was reduced by $7.8 million in FY 02 in order for Title V to operate within federal and state appropriations.

Form 4 shows a leveled distribution of expenditures across MCH population types, with the exception of children with special health care needs between FY 01 and FY 02. Variations in expenditures for pregnant women, infants less than 1 year old, and children between the ages of 1 and 22 are proportional and these variations are due mainly to the Title V FY 02 budget realignment. Expenditures for CSHCN decreased from $41,346,111 in FY 01 to $35,650,770 in FY 02 because to the fact that Title V was asked by the 77th Legislative Session to transfer one-time only $7 million in Title V funds to the Interagency Council on Early Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays.

While Form 5 indicates a variation in expenditures of about $1 million between FY 01 and FY 02 across population-based services, enabling services, and infrastructure building services, direct health care services showed a greater variation in expenditure of $4.2 million during the same period. The $1 million reduction in expenditures is due mainly to the FY 02 budget realignment and the direct health care services reduction is due to the transfer of $7 million to ECI.

B. BUDGET

FY 04 Application Update

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of $40,208,728. This represents $10 million in excess of the state matching rate of $3 state dollars for every $4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement

Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. The Title V program funds accountants within the Associateship For Family Health Financial Monitoring Division (FMD) whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. FMD staff prepare financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a quarterly basis. Title V program leadership reviews reports and provides feedback as needed.

To achieve the 30% - 30% requirement, the Title V contracts program requires all Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount.

For FY 04, Form 2 shows that $12,185,226 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional $12,185,226 for children with special care needs.

The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at $4,061,742 as shown in Form 2.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Oral Health Program; 4) MCHB - Texas Genetics Network; 5) MCHB - Newborn Screening Sickle Cell Program; 6) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 7) MCHB - Healthy Child Care North Texas; 8) Texas Cancer Council - regional school health specialists; 9) Centers for Disease Control and Prevention - Prevention of Secondary Disabilities; and 10) Childhood Immunizations - Integrated Public Health Information System.

Texas Title V Budget Alignment for the FY 02-03 Biennium

The Texas Legislature allocates Federal Title V block grant funding and state general revenue funding primarily to two strategies within the Texas Department of Health: 1) Maternal and Child Health (MCH) Strategy, and; 2) Children With Special Health Care Needs (CSHCN) Strategy. The Texas Legislature meets once every two years.

For the FY 02-03 biennium, Title V MCH Program initiated a coordinated process to align its budget within existing resources. This budget alignment was necessary because the Title V MCH Program budgeted for services over and above the annual state and federal appropriations for some time. Requests were made for additional state revenue funding for the MCH strategy in the TDH Legislative Appropriations Request for FY 2002 and FY 2003 but they were not funded.

In order to operate within the budget, Title V had to reduce its funded programs and workforce by an estimated of $7.8 million and $4.5 million based on the FY 01 and FY 02 budgets and projected expenditures, respectively. While Title V was able to address its $7.8 million budget reduction without decreasing funding to direct fee-for service contracts for FY 02, fee-for-service contracts and population-based projects were cut by about $1.2 million and $0.5 million, respectively in FY 03. Form 5 shows that direct health care services were budgeted at $75.6 million in FY 01 and at $61.6 million in FY 03. Similarly, funding for population-based services was diminished by close to one million from FY 01 to FY 03.

Texas Title V Budget reductions for the FY 04-05 Biennium

The Texas Department of Health (TDH) was asked by the Governor, the Lt. Governor, and the House Speaker to reduce its FY 2004-05 budget by 12 percent or approximately $117 million dollars since it was announced that the state faces a revenue shortfall of nearly $10 billion. Initially, Title V program was proposed for cut of $10 million in state appropriations, which represented the surplus over the MOE level. By the end the 78th Texas Legislative Session, in legislative Conference Committee, a decision was made to cut Title V by about

$7 million instead of $10 million, as a result of pressure from advocacy groups and efforts from the TDH leadership. Nonetheless, during the session, there were many tentative actions to cut further Title V state appropriations but such actions did not materialized because of the requirement that stipulates that states must maintain funds provided for MCH health programs at a level at least equal to the level provided by the states in fiscal year 1989. The Texas' level of expenditures for MCH services in 1989 was $40,208,728.

As expected, Form 3 indicates a significant decrease in state budgeted funds from $58.1 in FY 01 to $43.8 in FY04. For FY 04, despite the approximative $7 million reduction in state appropriations, the Title V client services will not be cut significantly because the program is projecting a carryforward amount of $4.8 from FY 03 into FY 04, as shown in Form 2. On the other hand, the demand for Title V services will increase in FY 04 and beyond as a result of the Texas Legislature's making several significant changes in CHIP and Medicaid programs in response to Texas' increasingly dire budget crisis. While coverage continues for all currently covered populations and the eligibility levels are maintained at 200% of the FPL, significant changes in CHIP program eligibility and coverage will have an impact on Title V program. These changes include, but are not limited to: changes in continuous eligibility from 12 to six months, reduction by 5% of provider reimbursement rates, exclusion of dental care and other critical services from the current benefit package. Similar changes are facing Medicaid program. Legislators made over 19 significant changes to Medicaid. Among the changes are the establishment of enhanced asset verification and the continuation of coverage for adult pregnant women over 158% of the FPL (currently, pregnant women are covered up to 185% of FPL). All these changes coupled with a sluggish economy will make access to care even harder and result in higher health care costs.

VI. REPORTING FORMS – GENERAL INFORMATION

This section is completed when you enter data for Forms 2 –21 online. Form 1 (SF 424) needs to be completed offline and mailed to the Maternal and Child Health Bureau. See IB, General Requirements, Face Sheet. *See Appendix G*.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

This section is completed when you complete your State Performance Measure Detail Sheets online (Form 16). The National Performance Measure Detail Sheets are provided for you. *See Appendix H*.

VIII. GLOSSARY

The glossary from the guidance is provided by clicking on the "I" icon from the State Narrative Main Menu. If you have customized a glossary for your State, provide it as an attachment.

IX. TECHNICAL NOTE

The technical note from the guidance is provided by clicking on the "I" icon from the State Narrative Main Menu.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

Appendix A – FY 2004 Update of Needs Assessment Process

Needs Assessment Process

There were no significant changes in health status indicators and systems developments included in the FY 2000 five-year needs assessment for the MCH and CSHCN populations. The Research and Public Health Assessment Division (R&PHA) in consultation with programs' staff is reviewing and updating the five-year need assessment methodology and procedures to improve the ongoing monitoring of pertinent health indicators and health outcomes, and several other significant projects both locally and statewide. These efforts are geared toward improving the quality, quantity, and availability of information on which to base MCH and CSHCN preventive strategies and related public policy. The review process consists of finding more efficient ways to: 1) collect, analyze, and report data trends in health status indicators and to target those that need attention to achieve the national and state performance measures, core health status indicators, and developmental health status indicators; 2) collect data that help identify and address the underlying causes of higher levels of diseases in racial and ethnic minority communities; and 3) involve local communities in the process by developing a plan for more local input and consumer input, for both MCH and CSHCN programs.

Needs Assessment Content

In the FY 03 submission, a set of five priorities were described in the Needs Assessment Section and are as follows: 1) to improve immunization rates; 2) to promote healthy eating and regular physical activity; 3) to eliminate health disparities; 4) to improve the ability of TDH to respond to disasters or disease outbreaks; and 5) to improve the efficiency and effectiveness of agency business practices. All these health status priorities, particularly health disparities, are crucial to the health and well-being of the MCH population. Title V is making a concerted effort to address and eliminate the unequal burden of disease experienced by many populations and to target more effectively prevention and control activities. Specific interventions for each of these five priorities will be developed in the next 5-year needs assessment cycle.

The following is an update of two recent needs assessment projects conducted in consultation with a diverse group of stakeholders. Information gathered from these two projects will be addressed in the next five-year needs assessment and most likely will be identified as Texas Title V priority needs.

1. Texas State Strategic Health Partnership

TDH, recognizing that the health of population is the shared responsibility of many entities, organizations, and interests including health service delivery

organizations, public health agencies, and the people of a community, convened representatives of our public health system to identify shared priorities and actions for improving the health of Texans. Through this Texas State Strategic Health Partnership (TSSHP), TDH is completing the Texas State Strategic Health Plan. The three part plan describes Texas' health status challenges, examines the state's public health system, and defines concrete, shared priority goals for public health improvement by 2010.

In July 2002, TDH released "The Health of Texans: Texas State Strategic Health Plan – Part I," summarizing the major and emerging health status issues in Texas. In August 2002, the Board of Health released the Public Health Improvement Plan: Texas State Strategic Health Plan - Part II addressing the need for a coordinated public health system as key to improving the health of the population of Texas. For two days in early October 2002 the Commissioner of Health convened a wide-ranging group of partners in the public health system. Led by a seventeen-member Public Health Improvement Steering Committee, the Texas State Strategic Health Partnership recommended six goals to improve state health status and six goals to improve the public health system by 2010.

Goal 1: Improve the health of all Texans by promoting healthy nutrition and safe physical activity.

Goal 2: Promote healthy choices with regard to risky behaviors including, but not limited to, tobacco use, risky sexual behavior, substance abuse, and violence to reduce the disease, disability, and premature death resulting from unhealthy choices.

Goal 3: Recognize mental health as a public health issue. Promote mental health and increase individual and community social connections in order to improve prevention, early detection, and treatment of mental disorders.

Goal 4: Increase rates of high school graduation, adult literacy, college attendance, and other advanced education and training thereby improving socioeconomic and health status.

Goal 5: Reduce health threats due to environmental and consumer hazards.

Goal 6: Reduce infectious disease in Texas with a focus on increasing rates of timely immunization among Texas children and adults.

Goal 7: By 2010, Texas state statute and local policy will ensure that essential public health services (emphasizing disease/injury prevention and health promotion) are available for all communities in Texas.

Goal 8: By 2010, a diverse set of governmental and non-governmental partners will actively participate and collaborate to provide the services necessary to meet the public health needs of Texans.

Goal 9: By 2010, Texas communities will be aware of the structure, function and availability of the public health system.

Goal 10: By 2010, the public health system workforce will have the education and training to meet evolving public health needs.

Goal 11: By 2010, the Texas public health system will be operating with a flexible funding system that efficiently and effectively meets the needs of communities for all public health objectives.

Goal 12: By 2010, the Texas public health system partners will be informed by, and make decisions based on, a statewide, real-time, standardized, integrated data collection and reporting system(s) for demographic, morbidity, mortality, and behavioral health indicators accessible at the local level which also protects the privacy of Texans.

In December 2002, the Partnership signed the Texas Declaration of Health based on the twelve goals, and established the process to further develop each goal and to continue the building momentum and collaboration for public health improvement.

In March 2003, The Texas Declaration for Health: Texas State Strategic Health Plan Part III was released by TDH on behalf of the Partnership. This Declaration invites new partners, summarized the Partnership process to date and provides the rational for the 12 goals adopted by the Partnership. It also includes the Commitments to Texas from the 76 organizations who provided their Commitments before publication.

Throughout 2003, Steering Committee members have and will continue to co-chair workgroups to research and establish action plans to reach measurable outcomes under each of the 12 goals by 2010. FY 2004 will see the continuation of progress toward meeting the goals.

The outcomes of these efforts will definitely shape much of the direction TDH took in FY 2003, all of which impact the women and children populations, and will serve as the blueprint for the Title V five-year needs assessment.

Detailed information on these efforts can be found at http://www.tdh.state.tx.us/oshp/sshp/sshp.htm.

2. Survey of CSHCN Client and Family Stakeholders

The goal of the project was to obtain information about CSHCN client/family stakeholders' opinions and use of program services. Data were gathered from responses to multiple-choice and open-ended questions. The telephone (83%) and face-to-face (15%) interviews were conducted by trained CSHCN staff and contractors in each Public Health Region.

Respondents were a convenience sample of parents and guardians of CSHCN clients and clients over 18 years of age. A total of 920 interviews were conducted, which was 22% of the total CSHCN population in May 2002. Of these, a total of 238 (25.8% of the sample and 26.4% of all wait-listed clients in May 2002) were clients on the waiting list for medical and/or family support services.

A total of 743 (80.8%) respondents were parents/guardians of CSHCN clients receiving services. A total of 149 (16.2%) of the respondents were parents, guardians, or clients on the waiting list for medical services. The remaining respondents were parents/guardians of clients on the waiting list for family support services or respondents with unknown program status. Approximately 37% of all families used only CSHCN resources for the client's health care, 27% used both Medicaid and CSHCN resources, 17% used both CHIP and CSHCN resources, and 20% used either SSI or private insurance and CSHCN resources.

The most frequently used services were doctor visits (59%), followed by prescriptions (48%), case management (41%), hospital care (38%). Transportation services (27%), equipment (22%), dental (14%) and family support services (7.4%) were also used by the respondents. Doctor visits, prescriptions, and hospital care were most commonly rated as the first, second, or third most important services.

Findings indicated that:

Over 71% of respondents said they had case management. A total of 616 (66.9%) said having case management as "somewhat important" or "very important". Another 6.4% said that having case management was "unimportant" (either "very" or "somewhat"). A total of 27% did not answer this question.

About 90% of respondents described CSHCN services as "somewhat important" or "very important." Most respondents (78.2%) indicated they were "very satisfied" or "somewhat satisfied" with the CSHCN program and its services. Open-ended comments (n=1498) indicated strong support for CSHCN services.

The majority of respondents (61.5%) said that medical services were more important than family support services, while 34% said that both were equally important. About half (n=465, 50.5%) said they did not need family support services.

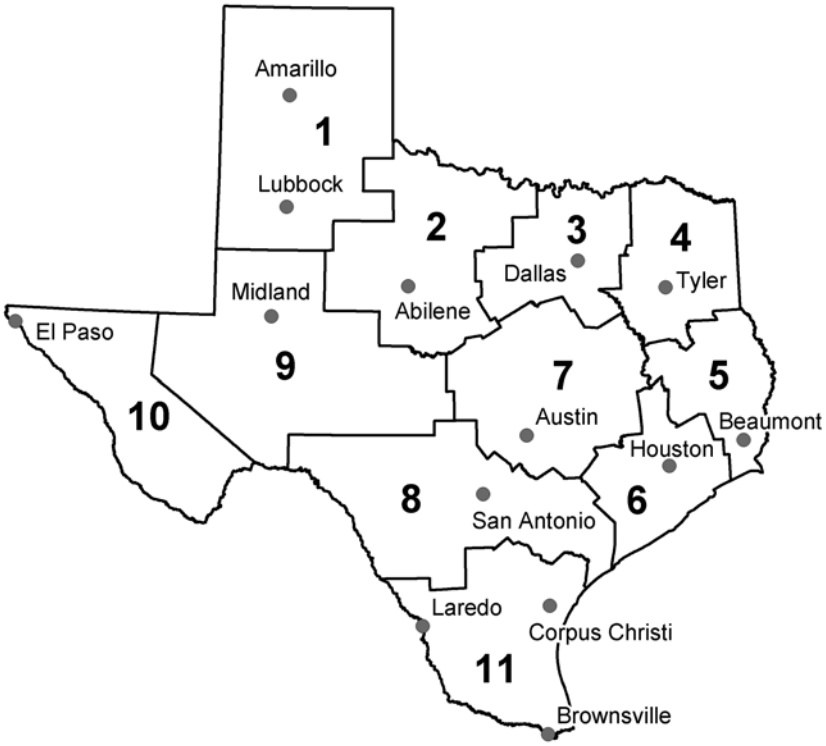
In a hypothetical decision-making question, the majority of all respondents (87.4%) would allow a wait-listed client to move to the top of the list if his/her condition were life-threatening.

Among wait-listed respondents, open-ended comments revealed that the respondent did not know how he/she felt about CSHCN because his/her child is wait-listed (n=23), the waiting list is too long or should not exist (n=13), and the respondent was frustrated or unsatisfied because his/her child was wait-listed (n=23).

Respondents' language preference was associated with statistically significant differences in use of services and financial resources. Respondents preferring Spanish were more likely to be wait-listed, to have an urban residence, to use only CSHCN funding, and to use CSHCN funding for doctor visits, hospital care, equipment, PT/OT, speech therapy, and orthotics/prosthetics.

Appendix B – Map of Texas Public Health Regions

MAP



Appendix C – Other MCH Capacity

Table 1 – Number and Classification of FTE personnel funded by the federal-state Title V Program.

Job Description	Central Office
Accountant	5
Administrative Tech.	33
ADP Supervisor	0
Chemist	3
Clerk	5
Contract Specialist	2
Data Base Administrator	3
Data Entry Operator	2
Director	10
Epidemiologist	0
Executive Assistant	5
Information Specialist	0
Laboratory Technician	5
Machine Service Technician	1
Manager	13
Medical Technologist	52
Microbiologist	6
Network Specialist	12
Nurse	13
Physician	6
Program Administrator	3
Program Specialist	18
Programmer	8
Public Health Technician	10
Purchaser	2
Registered Therapist	1
Research Specialist	2
Training Specialist	1
Staff Services Officer	4
Statistician	4
System Analyst	12
System Support Specialist	3
Total:	244

Table 2 – Positions funded by federal-state Title V Program by Public Health Region

Job Description	PHR 1	PHR 2/3	PHR 4/5	PHR 5/6	PHR 7	PHR 8	PHR 9/10	PHR 11	Total
Accountant	0	0	0	0	0	0	0	1	1
Administrative Tech.	2	10	2	10	7	5	9	7	52
Caseworker	0	0	0	0	0	0	0	3	3
Clerk	0	0	6	1	5	4	3	8	27
Custodian	0	0	0	0	0	0	0	1	1
Epidemiologist	0	2	0	0	0	0	0	0	2
Human Services Specialist	4	13	12	11	6	8	6	11	71
Human Services Tech.	0	1	2	2	3	7	6	9	30
Licensed Voc. Nurse	0	0	0	0	0	1	1	6	8
Manager	1	2	3	1	2	0	1	1	11
Medical Aide	0	0	0	0	0	0	0	2	2
Inventory Coordinator	0	0	0	0	1	0	0	0	1
Medical Technologist	0	0	0	0	0	0	0	1	1
Nurse	2	8	14	11	5	10	11	11	72
Nutritionist	0	0	1	0	0	0	0	0	1
Public Health Technician	0	2	3	0	5	4	5	0	19
Physician	0	0	1	0	0	0	0	0	1
Program Administrator	1	3	2	1	1	3	3	2	16
Program Specialist	1	4	2	5	2	2	1	1	18
Purchaser	0	0	0	0	0	0	0	1	1
Radiological Technician	0	0	0	0	0	0	0	1	1
Secretary	0	0	0	0	1	0	0	0	1
Total: *	11	45	48	42	38	44	46	66	340

* Includes 4 Local Health Departments and the South Texas Women's Hospital in Harlingen.

Central Office Title V Positions includes ICES, ADS, Grants Management, Injury Prevention and Control Program, Birth Defects Monitoring Program, Cytology Lab - San Antonio, Genetics Lab - Austin, TDH Lab - Austin, & Flouridation

Appendix D – Qualifications: Senior Level Employees

TEXAS DEPARTMENT OF HEALTH

TITLE V AND RELATED PROGRAMS

Qualifications: Senior Level Employees

Executive Deputy Commissioner

Nicolas U. Curry, M.D. is currently serving in the position of Executive Deputy Commissioner for the Texas Department of Health (TDH). He assumed this position on March1, 2003. Under broad delegation of authority from the Commissioner of Health, Dr. Curry provides executive leadership, guidance and support for TDH programs relating to the following: Associateship for Family Health, Associateship for Disease Control and Prevention, Associateship for Consumer Health Protection, Office of Public Health Practice, Office of Minority Health, and Office of the State Epidemiologist. Additional responsibilities include oversight of the 8 public health regions.

Previously, Dr. Curry served as the Director of TDH Public Health Region 1. His duties included coordination and oversight of the delivery of comprehensive public health services in 41 counties, developing and supporting community health partnerships, and managing regional resources.

Prior to coming to TDH Dr. Curry served as the principal for CCA Health Systems where he provided consultation on health systems management, health policy, health risk communications, and health organizations management. He has also served as the President and Chief Executive Officer of the Community Health Foundation of Tarrant County, Inc. Dr. Curry was the Director of Public Health for Tarrant County Health Department and City of Fort Worth Health Department after serving as the Chief for Clinical Services for the City of Houston Health Department.

Dr. Curry holds a Master's of Science degree from the University of Georgia and a Master's in Public Health from the University of Alabama at Birmingham. He received his medical degree from Baylor College of Medicine. He is Board Certified in Public Health and General Preventive Medicine, and in Quality Assurance and Utilization Review.

ASSOCIATESHIP FOR FAMILY HEALTH

Associate Commissioner for Family Health

Ms. Debra Wanser, R.N., M.P.Aff. was named Associate Commissioner for Family Health effective January 1, 2002. The Associateship for Family Health

includes most of the Texas Department of Health programs for women and children, including Maternal and Child Health Program, Children with Special Health Care Needs Program, WIC, Texas Health Steps (EPSDT), Family Planning (Titles X, XX and XIX), Breast and Cervical Cancer Control Program and Oral Health Services. Ms. Wanser has been with the Texas Department of Health for ten years. During this time, she served in various positions including State Title V Director; Acting Director for Policy, Planning and Operations; and Policy Coordinator for the Children with Special Health Care Needs Program. Ms. Wanser has over 25 years experience in the areas of children's mental health, school health, and public health policy and administration.

Ms. Wanser received an Associate of Nursing Science degree from Oklahoma State University, a bachelor's degree in Health Care Administration from St. Edwards University, Austin, Texas and a master's degree in Public Affairs from the Lyndon B. Johnson School of Public Affairs, University of Texas.

ASSOCIATESHIP FOR FAMILY HEALTH

Bureau of Women's Health

Bureau Chief

Ms. Margaret Mendez serves as the Chief for the Bureau of Women's Health, which was established in March 2000. The Bureau of Women's Health includes the Breast and Cervical Cancer Control Program, the Family Planning Division, the Office of Women's Health, the Women's Health Laboratory, Prenatal and Maternity Services, Osteoporosis Program, and the Office of Special Projects, which includes Breast-feeding Initiative activities, projects for Male Involvement, and Family Violence Prevention. From 1991 until her appointment as Bureau Chief, Ms. Mendez served as the Director for the Breast and Cervical Cancer Control Program with the Texas Department of Health. She served as the director for a multi-purpose community health care center responsible for providing acute, preventive, and chronic care for all age groups in addition to providing support services for families. She held several positions as a policy analyst and health planner at the Texas Department of Health, a local health department, and the Governor's Office. Ms. Mendez received a bachelor's degree from the University of Texas at Austin and a Master of Public Affairs Degree from the LBJ School of Public Affairs at Austin.

ASSOCIATESHIP FOR FAMILY HEALTH

Bureau of Children□s Health

Bureau Chief

Ms. L. Jann Melton-Kissel, RN, MBA, serves as Chief for the Bureau of Children's Health effective May 2002. The Bureau of Children's Health includes five divisions: Child Wellness, CSHCN Planning and Policy Development, Genetic Screening and Case Management, Oral Health, and Texas Health Steps (formerly EPSDT). As Chief of the Bureau of Children's Health, Ms. Melton-Kissel has the responsibility for directing, planning, implementing, and evaluating health services for children in Texas. The Bureau continues its focus on increasing service integration, and is working to assure that systems are accessible for clients, community members, and providers.

Ms. Melton-Kissel has been employed with TDH since 1986. Before coming to TDH, Ms. Melton-Kissel worked in a large metropolitan teaching hospital in the field of obstetrical nursing. She began employment with TDH in 1986, working in the Health Care Facility Regulatory Program. Over the years, Ms. Melton-Kissel has held multiple positions at TDH at the Division, Bureau, and Associateship levels gaining experience in budget and management.

ASSOCIATESHIP FOR FAMILY HEALTH

Bureau of Nutrition Services

Bureau Chief

Mr. Mike Montgomery serves as Chief for the Bureau of Nutrition Services and is the State WIC Director. The Bureau of Nutrition Services includes five divisions: Public Health Nutrition, Provider Relations, Vendor Operations, Training and Technical Assistance, and EBT Planning. As Chief of the Bureau of Nutrition Services, Mr. Montgomery has responsibility for directing, planning, implementing, and evaluating WIC and public health nutrition services for children in Texas. The Bureau continues its focus on increasing service integration, and is working to assure that systems are accessible for clients, community members, and providers.

Mr. Montgomery has been employed with TDH in the WIC program since 1996. Much of his professional career was spent in various management and executive positions with the U.S. Department of Agriculture (USDA) including service as a USDA regional director for five state WIC programs from 1977 to 1982. He also served in executive positions with the Food and Consumer Service in USDA's regional office. After his retirement in 1994, he served as a management consultant with WIC through the City of Dallas Department of Environmental and Health Services and then as head of Texas WIC's project development team for the Electronic Benefits Transfer Program.

ASSOCIATESHIP FOR FAMILY HEALTH

Bureau of Support Services

Bureau Chief

Mr. Gerald D. (Gerry) Cannaday was named as the Chief of the Bureau of Support Services in November of 2001. His responsibilities include administration of several divisions including: Financial Management Division, Automation Planning Division, Quality Assurance & Monitoring Division, Research & Public Health Assessment Division, and Health Communications Division. The Bureau of Support Services primary mandated responsibilities are Data Management and Reporting, Financial Management, Media Services, Computer Support, and Purchasing. Mr. Cannaday has over thirty years of experience managing and leading a variety of organizations. Much of that experience includes managing large programs and managing automation improvement projects. He came to the Texas Department of Health in 1996 to assist in the development of an EBT system for WIC.

Mr. Cannaday holds a B. A. Degree in Mathematics.

ASSOCIATESHIP FOR FAMILY HEALTH

Title V Director: Maternal and Child Health

Dr. Fouad Berrahou was named State Title V Director effective July 2002. He is responsible for coordinating the management and administration of the Texas Title V program and reports directly to the Associate Commissioner for Family Health. He also oversees the Primary Health Care Contracts Program and the County Indigent Health Care Program. In July 2003, he assumed responsibility for managing the Federally Qualified Health Center. Program to position strategic health care entities to apply for and receive support as FQHCs. Dr. Berrahou has been with TDH for nine years. During this time, he worked in a variety of capacities as a health planner and assistant to the State Title V Director within the Associateship for Family Health programs and within TDH special projects.

Dr. Berrahou professional interests include: strategic planning, health needs assessment, program monitoring and evaluation, statistical methods and data analysis, systems and processes development to improve health and address health disparities at the local community, and policy development.

Dr. Berrahou graduated from the "Universite' Des Sciences and Technologies" (Oran, Algeria) with a bachelor degree in Architecture, specializing in health care facility design; he received his master degree from the College of Architecture of

the University of Houston; and completed his Ph.D. in health planning from Texas A&M University in 1993.

ASSOCIATESHIP FOR FAMILY HEALTH

Title V Director: Children with Special Health Care Needs

Lesa R. Walker, M.D., M.P.H., as of June 1, 2002, is the Acting Director of the Children with Special Health Care Needs (CSHCN) Division in the Bureau of Children's Health. She is primarily responsible for direction and leadership of the Children with Special Health Care Needs Program and the overall health care policy and systems development for CSHCN.

Dr. Walker has been employed at the Texas Department of Health for 16 years. From September 1996 until June 2002, she served as the Director of Systems Development in the CSHCN Division. From May 1994 to September 1996, she was the Director of Special Initiatives in the Children's Health Division, focusing on special initiatives pertaining to CSHCN. From October 1993 to May 1994 she was the Director of the Children's Health Division, which included the Chronically Ill and Disabled Children's Services Program (CIDC; currently the CSHCN Program) as well as EPSDT (now Texas Health Steps). From April 1993 to October 1993 she served as the Acting Bureau Chief for the CIDC Bureau. From May 1986 to April 1993 she was the Medical Director for the CIDC Bureau.

Her educational background is as follows: B.A. in Biology, 1976, from the University of Texas at Austin, Texas; M.D., 1980, from Baylor College of Medicine in Houston, Texas; M.P.H., 1982, from the University of Texas School of Public Health in Houston, Texas; Pediatric internship (Baylor College of Medicine in Houston, Texas and the Medical College of Ohio in Toledo, Ohio); Preventive Medicine/ Public Health Residency at the University of Michigan School of Public Health in Ann Arbor, Michigan; Board Certification in General Preventive Medicine/ Public Health by the American Board of Preventive Medicine, January 31, 1989.

Appendix E – CSHCN & MCH Related Advisory Committees

Advisory Committee Membership Summary		
Advisory Committee	**Total Members**	**Consumer / Advocate Members**
Children with Special Health care Needs Advisory Committee	18	11
Breast and Cervical Cancer Control Program Advisory Committee	6	0
Family Planning Advisory Committee	15	5
Oral Health Services Advisory Committee	11	4
School Health Advisory Committee	16	6
Adolescent Health Advisory Committee (group disbanded as of Spring 2003)	18	6
Osteoporosis Advisory Committee	17	6

Appendix F – State Priorities – Assessment of Performance Measures

National Performance Measures.

The following is a performance assessment for each of the national performance measures. We also included in this assessment the new CSHCN performance measures to show the extent of the programmatic efforts needed to achieve the annual performance objectives.

01. Percent of infants who are screened for conditions mandated by their State-sponsored newborn screening programs (Phenylketonuria and hemoglobinopathies) and receive appropriate follow-up and referral as defined by their State. (National Newborn Screening and Genetic Resources Center) (New Measure).

Performance Assessment: Continual and expanded efforts to assure aggressive case management of identified presumptive positive cases and to increase parents' awareness of the legal requirement for newborn screening helped TDH to reach the performance indicator of 96.49% (360,996) of newborns having at least one screening in FY 2002.

02. The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey)

Performance Assessment In FY 2002, according to the national CSHCN SLAITS survey, 57 percent of children with special health care needs aged 0-19 years whose families partner in decision making at all level reported that they were satisfied with the services they received. While this represents a majority of families satisfied with services there is still room for progress toward the annual performance objective of 67 percent. FY 2004 planned activities related to this performance measure should lead to progress toward reaching the performance objective. These activities include continuing information and formal mechanism for partnering in decision making with families of CSHCN and promoting family networking and requiring and confirming that all service contractors have quality assurance plans as well as providing technical assistance and training to contractors so that by FY 2005 all the plans include ways to measure progress toward family partnership and satisfaction

03. The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Performance Assessment: In FY 2002, according to the national CSHCN SLAITS survey, 58.3 percent of children with special health care needs age 0 to 18 receive coordinated, ongoing, comprehensive care within a medical home.

Activities planned for FY 2004 will help the Texas CSHCN program move toward the annual performance objective of 68 percent. These activities include informing CSHCN medical providers and families of the principles and practice of providing/obtaining and using a medical home through participation in the Medical Home Training Conference. CSHCN will also disseminate materials relating to best practices as well as education and training opportunities on this topic via bulletins, family newsletter and the program's web site. Case management efforts will continue and the program will document those efforts to connect CSHCN with medical homes.

04. The percent of children with special health care needs age 0-18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Performance Assessment: About 52.9 percent of the families of children with special health care needs aged 0 to 18 reports that they have adequate private and/or public insurance to pay for the services they need according to the CSHCN SLAITS survey. Activities planned for FY 2004 to facilitate progress toward the annual performance objective of 63 percent include documenting payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance, document providing of health care benefits to those eligible for CSHCN services and finally documenting the number of CSHCN on the waiting list by age and region who have no other source of insurance. Collection of this baseline data will facilitate development of future actions to progress toward meeting the annual performance objective further.

05. The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey)

Performance Assessment: Over three quarters of parents with CSHCN surveyed in the CSHCN SLAITS survey report that community-based service systems are organized so they can use them easily. While this majority percentage demonstrates a certain level of satisfaction, there is still room for progress toward the annual performance objective of 87 percent. FY 2004 planned activities in this area include continuing to fund contracts to support community-based service systems' infrastructure organization and coordination and CSHCN continued participation in state level forums on issues pertaining to CSHCN. The CSHCN program will also continue to publicize and gather/monitor public input and feedback on the program and service delivery via the toll free information and referral line, as well as the program's website. This interactive and proactive approach should see progress toward the 87 percent objective in the coming year.

06. The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life. (CSHCN Survey)

Data not available.

07 Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Performance Assessment: Data show that 71.6% of children through age two completed immunization shots in FY 2002. This represents a decrease in the number of children immunized from FY 01, which makes the state unable to achieve unable the state to achieve the 80% target objective. As a result, the Commissioner of Health has directed TDH's programs serving children to increase immunization levels for two-year-olds to 90 percent by December 31, 2005. A report has been developed that contains several proposed strategies for achieving the Commissioner's goal. Community involvement, provider and parental awareness and participation, improvement of data systems (such as IMMTRAC), and bringing elements of TDH operations that touch on immunizations together to formulate a uniform strategy are all methods that TDH proposes to utilize in order to improve Texas Immunization levels.

08 The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Performance Assessment: At a rate of 42 per 1,000 births in FY 2002, Texas continues to perform better than the annual program performance objective of 50 per 1,000 births, although the performance indicator has increased from FY 2000 (38.9 per 1,000 births). The availability of family planning services, as well as the provision of resources to facilitate contractors with their educational efforts, contributes to keeping the numbers below the objective. Other state and community-level efforts, including abstinence programs and school-based education may also contribute. It is unclear why the rate of birth for teenagers is increasing after the dramatic decrease noted in FY 2001.

09 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Performance Assessment: Data reveal that the FY 2002 performance objective of 20% for third-grade children receiving sealants was exceeded, with 37.5%, or 2,687 children, receiving sealants. This represents an increase from 21.7% in FY 01. However, it should be noted that data are limited, because the denominator includes only children in the Free Lunch program. This improvement could be attributed to several activities such as, the "Tattle Tooth" Curriculum that was used to provide oral health education to 40,310 school children in Texas during FY 2002.

10 The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Performance Assessment: There were 262 deaths from motor vehicle crashes among children aged 1-14 years in 2002, representing a fatality rate of 5.6 per 100,000 children. This rate reveals that the FY 2002 performance objective of 5.5 deaths to children 1-14 years caused by motor vehicle crashes was exceeded. More efforts are needed to educate parents, schools, children and adolescents on the use of age-appropriate restraint systems and traffic and safety information. In addition, Title V program's contract with the Texas A&M Extension Service will continue to implement parent education train-the trainer workshops and increase the number of trained community professionals to 250. These 250 professionals will each commit to teaching parents and increasing parents' knowledge and skills relating to health, car seat safety, child development and nutrition.

11. Percentage of mothers who breast-feed their infants at hospital discharge.

Performance Assessment: Texas percentage of mothers who breastfed their infants at hospital discharge increased from 1998 to 2002, with 63.1% and 69.7% respectively. Despite this increase, the performance objective of 80% has not been met. Training health professional staff and facilitating hospitals to become more breastfeeding-friendly contribute to creating an environment that both encourages breastfeeding and assists women in their early efforts. The Lactation Hotline and the website are two means of educating mothers, families and professionals in preparation for breastfeeding and in maintaining breastfeeding after initiation. All state-provided resources are available to, breastfeeding promoters at the local level. Often it is the connection with a caring, informed individual that encourages a new mother to initiate and maintain breastfeeding.

12 Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Performance Assessment: Major success occurred in increasing the percentage of newborns that have been screened for hearing impairment before hospital discharge. In FY 02, 313,972 screens were made, representing a 84.3% of the total population of occurrent births. Statewide mandatory testing begins late in 2000. More efforts are needed to achieve the target objective of 92% for FY 03.

13 Percent of children without health insurance.

Performance Assessment: More than 1.3 million children or about 23% of the population ages 0-18 years were uninsured in 2002, representing an increase of the number of uninsured children from 2001. Data also reveals that 30% or more

of these uninsured children are clustered along the Texas-Mexico border area. Despite the increase of children enrolled CHIP and also in Medicaid program as a result of CHIP screening and referral process, children without insurance remain a pressing statewide concern. For the FY 04-05 Biennium, the problem may worsen because of the changes made to CHIP and Medicaid programs by the recently completed 78th Legislative Session in addressing the state budget shortfall.

14. Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Performance Assessment: In FY 2002, 1,661,900 children were potentially eligible for Medicaid. Of those, 726,473 (43.7%) received a service paid by the Medicaid program. Although the FY 2002 performance objective of 52% has not been met, data showed a significant improvement over FY 01 (37.7%).

15. The percent of very low birth weight infants among all live babies.

Performance Assessment: Many efforts are needed in pre-pregnancy planning to provide the best opportunity for positively affecting pregnancy outcomes, including reduction of VLBW live births, and in identifying key reasons why the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates is decreasing. While the percent of VLBW live births remained consistent in FY 2002 at 1.3%, that figure was above the 1.1% target. This is most likely due to several factors. First, at the state level, lack of staff and direction in maternal and child health in the past few years has slowed down the process of developing an infrastructure to address the problem of very low birth weight babies. Second, very low birth weight babies are an intractable problem with numerous variables. An effective and comprehensive strategy for reducing the number of VLBW babies has not been identified. A staff member has been hired in FY 2001 and charged with the responsibility of building the infrastructure necessary to address this and other perinatal health issues. Projects are underway such as, a Geographic Information Systems mapping project to identify existing perinatal systems and regional visits to share data and information to facilitate the process of building infrastructure.

16. The rate (per 100,000) of suicide deaths among youths aged 15-19.

Performance Assessment: An increase in the number of suicide deaths among youths, ages 15-19, was observed in FY 02, causing the suicide rate to worsen from 7.6 per 100,000 adolescents in FY 01 to 8.2. The FY 2002 performance objective target (10.5 per 100,000 adolescents) has not been met. In an effort to raise awareness surrounding suicide in Texas, the Adolescent Health Program will partner with the Bureau of Epidemiology in developing an article submitted to the Texas Department of Health, Disease Prevention News, which includes information pertaining to training available through the 20 Education Service

Centers. In addition, the Adolescent Health Coordinator is currently serving on an interim committee developing a statewide suicide prevention plan.

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Performance Assessment: The percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, was below its 55% projection at 52.1% in FY 2002. Data show that the percent remains consistent over the years. Despite the fact that Texas has been in a building mode in perinatal health infrastructure development, data indicate that perinatal systems do exist at the local level and are performing reasonably well, at least in terms of identifying pregnancies that will yield VLBW babies and ensuring that they are delivered at high risk facilities. Plans outlined by the Texas Department of Health for FY 2004 such as a Geographic Information Systems mapping project to identify existing perinatal systems and regional visits to share data and information will build upon the efforts of the existing systems and facilitate their efforts to continue to improve in this and other perinatal health areas.

18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Performance Assessment: The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester still remains a challenge for Texas. Despite the performance indicator shows an increase from 77.7% to 80.1% in FY 2001 and FY 20002, respectively, it is still significantly below the annual performance objective set at 85%. The continued improvement is mostly likely attributed to efforts and the state and local levels to promote the importance of prenatal care. Another contributing factor may be the presence of accessible, user-friendly sources of prenatal care. There is room for improvement, however, and efforts in place for FY 2004 such as building infrastructure among perinatal systems and a social marketing campaign promoting prenatal care will undoubtedly play a role.

State Performance Measures.

The following is a set of seven state performance measures derived from the current 5-year needs assessment cycle and related Title V program priority needs. In addition to completing Figure 4b, an update each state performance measure is provided below by level of service category.

Enabling Services

01. Change in institutionalized CSHCN, as percent of previous year.

Performance Assessment: Data indicate an increase of CSHCN in institutions from FY 2001 to FY 2002 despite a myriad of activities put in motion to produce a change in percent of institutionalized CSHCN, including recommendations put forth by the Promoting Independence Board to the legislature which resulted in two bills focusing on permanency planning, the recruitment of foster families on the part of TDH, and the continuation and expansion of the MDCP and the CLASS waiver programs. More efforts are needed to change this trend. The establishment of a CSHCN foundation will also help provide the family supports necessary to promote the reduction in the number of CSHCN who are currently institutionalized.

Population-based Services

02 Percent of children and adolescents (aged 13-19) who choose healthy behaviors.

03 Percent of infants and children (aged 0-12) who thrive.

Performance Assessment: Data indicate a 4.3% increase in the percent of children who choose healthy behaviors from 2001 to 2002 coupled with a similar reported 3.9% increase in the percent of infants and children (aged 0-12) who thrive. Many Title V activities that have been put in place have had a positive impact on the noted improvements. These activities include proactive training of parents on the importance of medical and dental check-ups, immunizations, child seat safety, suicide prevention and the like. In addition proactive plans in regards to suicide prevention, abstinence and teen pregnancy prevention, have had a positive impact on the progress toward meeting these important state performance measures. Synergistically, these performance measures and the related activities with them have had a significant positive impact on the health and well being of Texas' children.

04 Ratio of black low birth weight (LBW) rate to White LBW rate.

Performance Assessment: Although the FY 02 ratio of black low birth weight (LBW) to white LBW rate was lower than the ratio in FY 01, still the annual performance objective of 1.6 has not been met. FY 04 planned activities will contribute favorably to reduce the disparity (ratio) between black and white perinatal mortality. Examples of activities include the promotion of smoking cessation to African American women ages 13-44 in targeted areas.

05 The prevalence of childhood obesity

Performance Assessment: With 100,071 out of 416,010 (24.1%), WIC children ages 0-5 years being considered obese in FY 2002, Texas fell short of achieving its performance objective of 17%. For the same year, other recent studies indicate that school-aged children in Texas are more overweight than children in the U.S. as a whole. In addition, data reflect that the problem is greater for boys

than girls and for younger children (4th graders vs. 8th and 11th graders). There is also significant concern for minority children, with about 30% of 4th-grade Hispanic boys and African-American girls being overweight. Individual behavior change is at the core of all strategies to reduce obesity. However, such change can occur and be sustained only in an environment that provides opportunities for healthy food choices, regular physical activity and community and family involvement. Therefore, the Texas Commissioner of Health has identified the promotion of healthy eating and regular physical activity as one of TDH's top priorities.

Infrastructure Building Services

06. Incidence of carious lesions among 3rd to 7th grade children.

Performance Assessment: There were 8,092 third- to seventh-grade children with carious lesions in FY 2002, representing a prevalence of 43.2%. This prevalence was slightly higher than the predicted performance objective of 43%. However, the survey sample is restricted to children in the Free Lunch program. The Bureau of Children's Health, Oral Health Division is planning to change the sample size to be more representative of the general population. In order to achieve this, the Oral Health Division applied and received a grant from CDC on July 2002, to strengthen its capacity to monitor trends in oral diseases, improve oral health prevention education, and evaluate program efforts. Results will be available to enable the program to better develop and target oral health initiatives to schools and communities with oral health disparities.

07 Percent of female clients suspected of being victims of relationship violence.

Performance Assessment: In FY 2002, the percentage of female clients suspected of being victims of relationship violence was 3.9%, still higher than the performance objective target of 3.8%. Data show no improvements over past years. A staff person has been hired and activities outlined for FY 2003-04 such as implementing the statewide strategic plan to prevent violence against women, dissemination of family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers, and continue providing accessible abuse prevention and youth development training to Title V providers and others will play a role in improving performance.

Appendix F – National and State Performance Measures Chart by Pryamid Level of Service

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:
List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State				
1. Educating providers to reduce number of unsatisfactory screens.	☑	☐	☐	☐
2. Educating parents and health professionals about NBS benefits and requirements.	☐	☐	☑	☐
3.	☐	☐	☐	☐
4. This is a new measure, however ongoing activities relate to it and are included.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Partnering in decision making with families of CSHCN and promote family networking.	☐	☐	☑	☐
2. Requiring and confirming that service contractors have quality assurance plans.	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6. This is a new measure but planned ongoing activities are included.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Informing CSHCN providers and families of principles and practice of medical home.	☐	☐	☑	☑
2. Document case management efforts to connect CSHCN with medical homes.	☐	☑	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6. This is a new measure but planned ongoing activities are included.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Document payment of insurance premiums to help families maintain private insurance.	☐	☑	☐	☐
2. Document provision of health care benefits to those eligible for CSHCN services.	☑	☐	☐	☐
3. Document number of CSHCN on waiting list with no other source of insurance.	☑	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6. This is a new measure but planned ongoing activities are included.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Continuing to fund contracts to support community-based service systems.	☐	☑	☐	☑
2. Continuing to publicize and solicitpublic input and feedback on the CSHCN program.	☐	☐	☐	☑
3. Continuing participation in forums working on issues pertaining to CSHCN.	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6. This is a new measure but planned ongoing activities are included.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Ongoing participation on the Leadership Education in Adolescent Health Advisory Board.	☐	☐	☐	☑
2. Providing articles and information on transition for families and providers.	☐	☐	☑	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6. This is a new measure but planned ongoing activities are included.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Continuing contract to continue parent education on preventive health.	☐	☑	☐	☑
2. Developing recommendations for state plan to improve immunization rates.	☐	☐	☐	☑
3. Encouraging Title V and others to follow preventive health guidelines.	☑	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Providing family planning clinical and education services to adolescents.	☑	☑	☐	☐
2. Developing and distributing resource materials to raise public awareness of teen pregnancy.	☐	☐	☑	☐
3. Provide funding for community-based abstinence projects for adolescents and teenagers.	☐	☐	☑	☐
4. Provide funding for activities to reduce and prevent pregnancy among adolescents.	☑	☐	☑	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Conducting statewide survey to measure the prevalence of dental sealants.	☐	☐	☐	☑
2. Promoting sealant benefits via educational materials for parents and students.	☐	☑	☑	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Providing traffic-safety presentations to children regarding bicycle and car seat safety.	☐	☑	☐	☐
2. Distributing safety seats and education concerning their use to low income families.	☐	☑	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Monitoring breastfeeding rates using available data.	☐	☐	☐	☑
2. Improving community access to education and support resources by a variety of venues.	☐	☑	☑	☐
3. Encouraging accreditation in Texas Tens Steps and Baby Friendly Initiative.	☐	☐	☐	☑
4. Providing training and resources to physicians on benefits of breastfeeding.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Monitoring newborn hearing screening programs to ensure they meet certification criteria.	☐	☐	☐	☑
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Monitoring and reporting number of children without health insurance.	☐	☐	☐	☑
2. Screening of and referring of clients as appropriate to CHIP and Medicaid.	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Monitoring and reporting the ratio of Medicaid child recipients receiving services.	☐	☐	☐	☑
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Consulting with providers to reduce occurence of VLBW births.	☐	☐	☐	☑
2. Developing and implementing plan to reduce the incidence of perinatal HIV transmission.	☐	☐	☐	☑
3. Devising plan to address the role of perinatal HIV transmission in at risk population.	☐	☐	☐	☑
4. Ongoing support of the PRAMS system.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Continuing collaboration to provide Mental Health CPR resources to extension agents.	☐	☐	☑	☐
2. Seeking funding for implementing statewide suicide prevention plan.	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4A (continued)

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Establishing of regional perinatal care systems to reduce VLBW and other conditions.	☐	☐	☐	☑
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Providing consultation to increase incidence of women receiving early prenatal care.	☐	☐	☐	☑
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Change in institutionalized CSHCN, as percent of previous year.				
1. Continuing collaboration to support community living options for CSHCN.	☐	☐	☑	☑
2. Providing family support servies for CSHCN and their families.	☐	☑	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of children and adolescents (aged 13-19) who chose healthy behavior.				
1. Training conducted on youth risk reduction and youth health promotion.	☐	☐	☐	☑
2. Providing funding to CBOs to promote abstinence.	☐	☐	☑	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of infants and children (aged 0-12) who will thrive.				
1. Conducting parent education to promote benefits of preventive health.	☐	☐	☐	☑
2. Providing safety presentations to children about bicycle and car seat safety.	☐	☐	☑	☐
3. Distributing safety seats and education concerning their use to low income families.				

FIGURE 4B (continued)

	☐	☑	☐	☑
4. Promoting the development of resiliencey and other factors in youth.	☐	☐	☑	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Ratio of Black low birth weight rate to White low birth weight rate.				
1. Promoting smoking cessation to African American women, including pregnant women.	☐	☐	☑	☑
2. Providing training for providers on low birth weight and prematurity.	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The prevalence of childhood obesity.				
1. Continuing state plan and marketing plan development to prevent and control obesity.	☐	☐	☐	☑
2. Implementing health promotion activities related to physical activity and nutrition.	☐	☐	☑	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

FIGURE 4B (continued)

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Incidence of carious lesions among school children in Texas.				
1. Surveying caries prevalence among school children in Texas.	☐	☐	☐	☑
2. Promoting health benefits of fluoridation; maintaining systems and providing upgrades.	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of female clients suspected of being victims of relationship violence.				
1. Distributing family violence/sexual abuse prevention educational materials.	☐	☐	☑	☐
2. Providing web based abuse prevention and youth development training.	☐	☐	☐	☑
3. Developing strategic plan to prevent domestic violence.	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

Appendix G – Reporting Forms - General Information

FORM 2
MCH BUDGET DETAILS FOR FY 2004
[Secs. 504 (d) and 505(a)(3)(4)]
STATE: TX

1. FEDERAL ALLOCATION
(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:
$ 40,617,420

A.Preventive and primary care for children:

$ 12,185,226 (30 %)

B.Children with special health care needs:

$ 12,185,226 (30 %)

(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:

$ 4,061,742 (10 %)

(The above figure cannot be more than 10%)[Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $ 4,814,560

3. STATE MCH FUNDS (Item 15c of the SF 424) $ 43,821,011

4. LOCAL MCH FUNDS (Item 15d of SF 424) $ 0

5. OTHER FUNDS (Item 15e of SF 424) $ 567,000

6. PROGRAM INCOME (Item 15f of SF 424) $ 2,240,648

7. TOTAL STATE MATCH (Lines 3 through 6) $ 46,628,659
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 40,208,728

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 92,060,639

(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 99,999
c. CISS:	$ 0
d. Abstinence Education:	$ 4,922,091
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 463,378,305
h. AIDS:	$ 0
i. CDC:	$ 8,290,995
j. Education:	$ 0
k. Other:	
family planning	$ 12,638,533
NHSCPC	$ 325,373

10. OTHER FEDERAL FUNDS (SUBTOTAL of all Funds under item 9) $ 489,655,296

11. STATE MCH BUDGET TOTAL $ 581,715,935
(Partnership subtotal + Other Federal MCH Funds subtotal)

FORM NOTES FOR FORM 2

None

FIELD LEVEL NOTES

None

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(I-3)]

STATE: TX

	FY 2002		FY 2003		FY 2004	
	BUDGETED	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
1. Federal Allocation *(Line1, Form 2)*	$ 38,839,474	$ 37,760,516	$ 39,496,620	$ 0	$ 40,617,420	$ 0
2. Unobligated Balance *(Line2, Form 2)*	$ 3,700,936	$ 5,102,326	$ 0	$ 0	$ 4,814,560	$ 0
3. State Funds *(Line3, Form 2)*	$ 59,200,000	$ 55,500,000	$ 58,600,000	$ 0	$ 43,821,011	$ 0
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form 2)*	$ 500,000	$ 500,000	$ 550,000	$ 0	$ 567,000	$ 0
6. Program Income *(Line6, Form 2)*	$ 2,600,000	$ 2,500,000	$ 1,900,000	$ 0	$ 2,240,648	$ 0
7. Subtotal *(Line8, Form 2)*	$ 104,840,410	$ 101,362,842	$ 100,546,620	$ 0	$ 92,060,639	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 413,122,314	$ 404,342,334	$ 409,910,861	$ 0	$ 489,655,296	$ 0
9. Total *(Line11, Form 2)*	$ 517,962,724	$ 505,705,176	$ 510,457,481	$ 0	$ 581,715,935	$ 0
	(STATE MCH BUDGET TOTAL)					

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(l-3)]

STATE: TX

	FY 1999		FY 2000		FY 2001	
	BUDGETED	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
1. Federal Allocation *(Line1, Form 2)*	$ 36,891,982	$ 18,560,312	$ 37,526,660	$ 23,185,552	$ 37,511,570	$ 33,810,634
2. Unobligated Balance *(Line2, Form 2)*	$ 17,622,040	$ 17,622,040	$ 18,331,670	$ 18,331,670	$ 14,341,108	$ 14,341,108
3. State Funds *(Line3, Form 2)*	$ 62,000,000	$ 62,000,000	$ 56,700,000	$ 56,700,000	$ 59,200,000	$ 59,200,000
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 200,000	$ 200,000	$ 200,000	$ 200,000
6. Program Income *(Line6, Form 2)*	$ 500,000	$ 500,000	$ 900,000	$ 900,000	$ 2,000,000	$ 2,000,000
7. Subtotal *(Line8, Form 2)*	$ 117,014,022	$ 98,682,352	$ 113,658,330	$ 99,317,222	$ 113,252,678	$ 109,551,742
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 358,940,363	$ 328,274,359	$ 380,172,948	$ 352,746,737	$ 391,530,241	$ 370,834,407
9. Total *(Line11, Form 2)*	$ 475,954,385	$ 426,956,711	$ 493,831,278	$ 452,063,959	$ 504,782,919	$ 480,386,149
	(STATE MCH BUDGET TOTAL)					

FORM NOTES FOR FORM 3

FY 02 "budgeted" Unobligated balance must be changed to $5,102,326 (cannot make the needed change because the "FY 02 Budgeted" Column is inactive). This change is due to encumbrances that did not materialized in FY 01.

FIELD LEVEL NOTES

1. **Section Number:** Main
   Field Name: UnobligatedBalanceExpended
   Row Name: Unobligated Balance
   Column Name: Expended
   Year: 2002
   Field Note:
   The FY 02 Budgeted Unobligated balance must be changed to $5,102,326. This change is due to FY 01 encumbrances that did not materialized.
   Note: cannot make the needed change to the "FY 02 Budgeted" Column because it is inactive.

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TX

	FY 2002		FY 2003		FY 2004	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 18,388,027	$ 17,883,749	$ 17,634,936	$ 0	$ 18,486,501	$ 0
b. Infants < 1 year old	$ 191,055	$ 185,815	$ 183,230	$ 0	$ 192,078	$ 0
c. Children 1 to 22 years old	$ 25,733,551	$ 26,655,000	$ 24,679,621	$ 0	$ 22,614,810	$ 0
d. Children with Special Healthcare Needs	$ 39,882,520	$ 35,650,770	$ 38,249,113	$ 0	$ 29,768,284	$ 0
e. Others	$ 10,878,886	$ 10,580,541	$ 10,433,336	$ 0	$ 10,937,146	$ 0
f. Administration	$ 9,766,371	$ 10,406,966	$ 9,366,384	$ 0	$ 10,061,820	$ 0
g. SUBTOTAL	$ 104,840,410	$ 101,362,841	$ 100,546,620	$ 0	$ 92,060,639	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 75,000		$ 75,000		$ 0	
b. SSDI	$ 95,988		$ 95,998		$ 99,999	
c. CISS	$ 0		$ 0		$ 0	
d. Abstinence Education	$ 4,922,091		$ 4,922,091		$ 4,922,091	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 386,423,953		$ 385,993,364		$ 463,378,305	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 7,278,150		$ 7,921,210		$ 8,290,995	
j. Education	$ 0		$ 0		$ 0	
k.Other						
family planning	$ 0		$ 0		$ 12,638,533	
NHSCPC	$ 0		$ 0		$ 325,373	
NHSCPC/TBI	$ 774,927		$ 599,823		$ 0	
Title X Family Planning	$ 13,552,205		$ 10,303,375		$ 0	
III. SUBTOTAL	$ 413,122,314		$ 409,910,861		$ 489,655,296	

FORM 4

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND SOURCES OF OTHER FEDERAL FUNDS (II)

[Secs 506(2)(2)(iv)]

STATE: TX

	FY 1999		FY 2000		FY 2001	
I. Federal-State MCH Block Grant Partnership	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**	**BUDGETED**	**EXPENDED**
a. Pregnant Women	$ 19,779,960	$ 16,681,189	$ 20,529,890	$ 17,939,483	$ 19,480,654	$ 18,844,054
b. Infants < 1 year old	$ 452,238	$ 381,389	$ 499,390	$ 436,378	$ 202,407	$ 195,793
c. Children 1 to 22 years old	$ 27,063,455	$ 22,823,636	$ 25,852,336	$ 22,590,356	$ 27,751,949	$ 26,845,055
d. Children with Special Healthcare Needs	$ 40,640,449	$ 34,273,628	$ 42,456,313	$ 37,099,287	$ 43,060,581	$ 41,653,423
e. Others	$ 16,534,260	$ 13,943,967	$ 13,213,878	$ 11,546,587	$ 11,525,316	$ 11,148,685
f. Administration	$ 12,543,660	$ 10,578,543	$ 11,106,523	$ 9,705,131	$ 11,231,771	$ 10,864,732
g. SUBTOTAL	$ 117,014,022	$ 98,682,352	$ 113,658,330	$ 99,317,222	$ 113,252,678	$ 109,551,742
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 349,888		$ 289,951		$ 387,232	
b. SSDI	$ 115,950		$ 95,000		$ 140,038	
c. CISS	$ 0		$ 0		$ 0	
d. Abstinence Education	$ 4,922,091		$ 4,922,091		$ 4,922,091	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 342,575,886		$ 356,973,533		$ 366,252,815	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 1,045,669		$ 7,596,106		$ 7,787,000	
j. Education	$ 0		$ 0		$ 0	
k.Other						
NHSCPC	$ 265,373		$ 265,373		$ 325,373	
Title X Family Planning	$ 9,665,506		$ 10,030,894		$ 11,715,692	
III. SUBTOTAL	$ 358,940,363		$ 380,172,948		$ 391,530,241	

FORM NOTES FOR FORM 4

None

FIELD LEVEL NOTES

1. **Section Number:** I. Federal-State MCH Block Grant Partnership
   Field Name: CSHCNExpended
   Row Name: CSHCN
   Column Name: Expended
   Year: 2002
   Field Note:
   FY 02 "Budgeted" balance for CSHCN must be changed to $36,030,255. This change is due to a decrease in state general revenue funds experienced in FY 02 . As a result, the sub-total decreased from $104,840,410 (FY 03 Block Grant submission) to $101,362,842.

FORM 5

STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TX

TYPE OF SERVICE	FY 2002		FY 2003		FY 2004	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 70,542,772	$ 68,026,857	$ 67,653,658	$ 0	$ 61,783,941	$ 0
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 8,007,176	$ 7,425,122	$ 7,679,238	$ 0	$ 6,743,709	$ 0
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 14,885,052	$ 15,047,536	$ 14,275,428	$ 0	$ 13,666,603	$ 0
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 11,405,410	$ 10,863,327	$ 10,938,296	$ 0	$ 9,866,386	$ 0
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 104,840,410	$ 101,362,842	$ 100,546,620	$ 0	$ 92,060,639	$ 0

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

STATE: TX

TYPE OF SERVICE	FY 1999		FY 2000		FY 2001	
	BUDGETED	EXPENDED	BUDGETED	EXPENDED	BUDGETED	EXPENDED
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 78,482,286	$ 66,187,081	$ 76,419,472	$ 66,777,064	$ 76,203,038	$ 73,712,832
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 8,484,544	$ 7,155,337	$ 8,579,032	$ 7,496,552	$ 8,649,662	$ 8,367,003
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 17,551,546	$ 14,801,884	$ 16,347,713	$ 14,285,003	$ 16,079,412	$ 15,553,959
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 12,495,646	$ 10,538,050	$ 12,312,113	$ 10,758,603	$ 12,320,566	$ 11,917,948
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 117,014,022	$ 98,682,352	$ 113,658,330	$ 99,317,222	$ 113,252,678	$ 109,551,742

FORM NOTES FOR FORM 5

None

FIELD LEVEL NOTES

None

FORM 6

NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Sect. 506(a)(2)(B)(iii)

STATE: TX

General Instructions/Notes:
To successfully complete this form, you must first enter a value for "Total Births by Occurrence" and select the "Reporting Year" before you can enter data in the table. For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

Total Births by Occurrence: 371,429 | **Reporting Year: 2002**

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment(3)	
	No.	%			No.	%
Phenylketonuria	360,996	97.2	288	10	10	100
Congenital Hypothyroidism	360,996	97.2	7,227	183	183	100
Galactosemia	360,996	97.2	728	11	11	100
Sickle Cell Disease	360,996	97.2	170	170	170	100
Other Screening (Specify)						
Congenital Adrenal Hyperplasia (CAH)	360,996	97.2	1,934	27	27	100
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

FORM NOTES FOR FORM 6

None

FIELD LEVEL NOTES

1. **Section Number:** Main
   Field Name: SickleCellDisease_Confirmed
   Row Name: SickleCellDisease
   Column Name: Confirmed Cases
   Year: 2004
   Field Note:
   Our screen for sickle cell disease is a diagnostic test therefore the number of presumptive positives will equal the number of diagnosed cases

FORM 7

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V (BY CLASS OF INDIVIDUALS AND PERCENT OF HEALTH COVERAGE)

[Sec. 506(a)(2)(A)(i-ii)]

STATE: TX

General Instructions/Notes:
To successfully complete this form, you must first select the "Reporting Year" before you can enter data in the table. For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

Reporting Year: 2002

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	**(A) Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private/Other %**	**(E) None %**	**(F) Unknown %**
Pregnant Women	44,842	0.0	0.0	0.0	0.0	100.0
Infants < 1 year old	371,429	61.0	0.0	0.0	0.0	39.0
Children 1 to 22 years old	43,806	0.0	0.0	0.0	0.0	100.0
Children with Special Healthcare Needs	48,865	20.2	15.5	9.2	55.1	0.0
Others	47,456	0.0	0.0	0.0	0.0	100.0
TOTAL	556,398					

FORM NOTES FOR FORM 7

None

FIELD LEVEL NOTES

1. **Section Number:** Main
   Field Name: PregWomen_TS
   Row Name: Pregnant Women
   Column Name: Title V Total Served
   Year: 2004
   Field Note:
   Title V is not used to pay for deliveries in Texas.

2. **Section Number:** Main
   Field Name: Children_0_1_TS
   Row Name: Infants <1 year of age
   Column Name: Title V Total Served
   Year: 2004
   Field Note:
   Occurrent births, The title V program serves all births, including those of non-residents

3. **Section Number:** Main
   Field Name: AllOthers_TS
   Row Name: Others
   Column Name: Title V Total Served
   Year: 2004
   Field Note:
   Clients who receive Family Planning and Dysplasia services.

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V AND ENTITLED TO BENEFITS UNDER TITLE XIX
(BY RACE AND ETHNICITY)
[SEC. 506(A)(2)(C-D)]
STATE: TX

General Instructions/Notes:
To successfully complete this form, you must first select the "Reporting Year" before you can enter data in the table. For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

Reporting Year: 2002

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
DELIVERIES								
Total Deliveries in State	367,407	139,686	41,016	838	11,659	87	0	174,121
Title V Served	44,842	17,049	5,006	102	1,423	11	0	21,251
Eligible for Title XIX	179,890	68,393	20,082	410	5,708	43	0	85,254
INFANTS								
Total Infants in State	352,382	137,734	39,167	734	10,216	76	0	164,455
Title V Served	371,429	145,179	41,284	774	10,768	80	0	173,344
Eligible for Title XIX	240,016	93,814	26,678	500	6,958	52	0	112,014

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
DELIVERIES								
Total Deliveries in State	194,645	173,392	0	152,008	289	1,099	9,183	10,813
Title V Served	23,756	21,086	0	18,553	35	134	1,121	1,243
Eligible for Title XIX	95,302	84,588	0	74,426	141	538	4,496	4,987
INFANTS								
Total Infants in State	189,118	163,264	0	143,651	273	1,039	8,678	9,623
Title V Served	199,340	172,089	0	151,416	288	1,095	9,147	10,143
Eligible for Title XIX	128,813	111,203	0	97,844	186	708	5,911	6,554

FORM NOTES FOR FORM 8

None

FIELD LEVEL NOTES

1. **Section Number:** I. Unduplicated Count By Race
   Field Name: DeliveriesTotal_All
   Row Name: Total Deliveries in State
   Column Name: Total All Races
   Year: 2004
   Field Note:
   Title V is not used for deliveries in Texas.
   Deliveries are an aggregate of live births and fetal deaths.

2. **Section Number:** I. Unduplicated Count By Race
   Field Name: DeliveriesTitleV_All
   Row Name: Title V Served
   Column Name: Total All Races
   Year: 2004
   Field Note:
   NOTE: Title V is not used for deliveries in Texas.
   Deliveries are an aggregate of live births and fetal deaths.

   .

3. **Section Number:** I. Unduplicated Count By Race
   Field Name: InfantsTotal_All
   Row Name: Total Infants in State
   Column Name: Total All Races
   Year: 2004
   Field Note:
   NOTE: Title V is not used for deliveries in Texas.
   Deliveries are an aggregate of live births and fetal deaths.

   - The "Title V Served" number (Form 7: 371,429) is higher than the "Total Infants In State" number (Form 8: 352,382) since the Title V program serves all births, including those from non-residents.

   SOURCES:
   - Live births and fetal deaths obtained from the Bureau of Vital Statistics, Texas Department of Health (TDH), 2001
   - Number of infants for FY 2002 obtained from Texas State Data Center, Texas A&M University.
   - Title V infants served FY 02 obtained from the Title V Data System

4. **Section Number:** I. Unduplicated Count By Race
   Field Name: InfantsTitleV_All
   Row Name: Title V Served
   Column Name: Total All Races
   Year: 2004
   Field Note:
   - The "Title V Served" number (Form 7: 371,429) is the preliminary total of occurrent births in Texas for 2002. The number is higher than the "Total Infants In State" number (Form 8: 352,382) since the Title V program serves all births, including those from non-residents.

   SOURCE:
   Occurrent births preliminary total for 2002, Bureau of Vital Statistics, Texas Department of Health (TDH).

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

General Instructions/Notes:
Your State is required to maintain one MCH Toll Free Hotline. Please use this form to enter information about your state's primary hotline. If your state has more than one hotline, click here to provide information on the secondary/additional hotline(s). For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

	FY 2004	FY 2003	FY 2002	FY 2001	FY 2000
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 422-2956	(800) 422-2956	(800) 422-2956	(800) 422-2956	(800) 422-2956
2. State MCH Toll-Free "Hotline" Name	Family Health Services Information & Referral Line	Family Health Services Information & Referral Line	Family Health Services Information & Referral Line	Family Health Services Information & Referral Line	Family Health Services Information & Referral Line
3. Name of Contact Person for State MCH "Hotline"	Melissa Short	Melissa Short	Melissa Short	Melissa Short	Melissa Short
4. Contact Person's Telephone Number	(512) 458-7329	(512) 458-7329	(512) 458-7329	(512) 458-7329	(512) 458-7329
5. Number of calls received on the State MCH "Hotline" this reporting period			6,425	6,407	9,994

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM (OPTIONAL)
[SECS. 505(A)(E) AND 509(A)(8)]
STATE: TX

General Instructions/Notes:
Click to go back to the required hotline page. For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

	FY 2004	FY 2003	FY 2002	FY 2001	FY 2000
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

FORM NOTES FOR FORM 9

None

FIELD LEVEL NOTES

None

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY 2004
[SEC. 506(A)(1)]
STATE: TX

1. State MCH Administration:
(max 2500 characters)

The Texas Department of Health administers the Title V program. Within TDH, the Associateship for Family Health is responsible for administering all Title V programs, including MCH and CSHCN programs. In addition, the Associateship administers newborn screening; genetic services; family planning (under Titles X, XIX and XX); a women's cytology laboratory; Texas Health Steps Medical, Dental, Medical Case Management (EPSDT), and Texas Health Steps-Comprehensive Care Program (for CSHCN); Medicaid Medical Transportation; public health dental programs, including fluoridation and sealants; Pre- and School Vision and Hearing Screening Program; the Program for the Amplification of Children of Texas; Title XIX Targeted Case Management for Pregnant Women and Infants; WIC program; Breast and Cervical Cancer Control program; Osteoporosis Program; the Primary Health care Program; the County Indigent Health Care Program; and the Federally Qualified Health Centers Program.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 40,617,420
3. Unobligated balance (Line 2, Form 2)	$ 4,814,560
4. State Funds (Line 3, Form 2)	$ 43,821,011
5. Local MCH Funds (Line 4, Form 2)	$ 0
6. Other Funds (Line 5, Form 2)	$ 567,000
7. Program Income (Line 6, Form 2)	$ 2,240,648
8. Total Federal-State Partnership (Line 8, Form 2)	$ 92,060,639

9. Most significant providers receiving MCH funds:

local health departmens, universities, FQHCs, TDH public health regions, school districts, community-based organizations, private physicians case management provider organizations

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	$ 44,842
b. Infants < 1 year old	$ 371,429
c. Children 1 to 22 years old	$ 43,806
d. CSHCN	$ 48,865
e. Others	$ 47,456

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

- For FY 02, Title V program awarded a total of 114 service contracts to local health care providers through a competitive request for proposals process. - In FY 02, a total of 556,398 individuals received health and health-related services from Title V-funded providers and TDH public health regional offices. - Title V child/adolescent health care (primary care services for infants, well-child examinations, sick child and follow-up visits, nutritional visits, immunizations and case management, laboratory services) as well as dental services (periodic oral evaluation, fluoride treatments, sealants and extraction as needed) are provided. - Preventive and primary care are provided for pregnant women, mothers, and women of childbearing age and include prenatal (initial, return, and postpartum visits, ultrasound, nutrition education, case management, and lab. services), dysplasia services (initial and return visits, colposcopy, biopsy, and conservative treatments for cervical cancer), and family planning services. - Title V staff continue to work with the Health and Human Services Commission to provide stronger coordination with the Texas CHIP and Medicaid Programs.

b. Population-Based Services:
(max 2500 characters)

- Current Title V population-based initiatives are arranged into two major categories: those which are implemented through Title V-funded contractors targeting local areas or a group of individuals, and those that are delivered by the TDH central and regional offices, with a statewide impact. - The first category includes population-based projects awarded to local entities through a competitive request

for application process in order to address a range of health disparities for minority groups and groups living in rural areas in Texas. - The second category includes a variety of population-based projects with a statewide impact, delivered by TDH Central and regional offices. Some major initiatives currently being undertaken are: Vision and Hearing Screening Program, Spinal Screening Program, Newborn Screening Program, Sounds of Texas Program, School Health Program, Breastfeeding Initiative, and Regional Perinatal Health Systems Initiative.

c. Infrastructure Building Services:
(max 2500 characters)

- Receive funding for CDC PRAMS implementation, which has started in FY02 and the data will be used to inform a number of important MCH efforts, including the Perinatal Health Systems. - Continue to maintain a Memorandum For Understanding involving all 13 Texas health and human state agencies to coordinate services to children and youth whose service needs are from more than one state agency. - Continue implementing and evaluating Service Delivery Integration efforts by integrating, streamlining, and standardizing policies and procedures of several programs and by supporting the development and implementation of an automation system for contract monitoring, including client eligibility, reporting, and billing capabilities. - Implement a distribution system for bicycle helmets and child safety seats to eligible families.

12. The primary Title V Program contact person:

Name	Fouad Berrahou, Ph.D.
Title	Director, Associateship for Family Health
Address	Texas Department of Health1100 West 49th Street
City	Austin
State	TX
Zip	78756
Phone	(512) 458-7321
Fax	(512) 458-7358
Email	fouad.berrahou@tdh.state.tx.us
Web	

13. The children with special health care needs (CSHCN) contact person:

Name	Lesa Walker, MD
Title	Medical Director, CSHCN Division
Address	Texas Department of Health1100 West 49th Street
City	Austin
State	TX
Zip	78756
Phone	512-458-7700
Fax	512-458-7238
Email	lesa.walker@tdh.state.tx.us
Web	

FORM NOTES FOR FORM 10

None

FIELD LEVEL NOTES

None

Appendix H– Performance and Outcome Measure Detail Sheets

FORM 11
TRACKING PERFORMANCE MEASURES
[SECS 485 (2)(2)(B)(III) AND 486 (A)(2)(A)(III)]
STATE: TX

PERFORMANCE MEASURE # 01

The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	96.8	97.4	86.5	86.5	86.5
Annual Indicator	96.1	97.0	97.0	96.1	97.2
Numerator	332,588	342,236	357,100	356,170	360,996
Denominator	346,216	352,960	368,019	370,458	371,429
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	86.5	86.5	86.5	86.5	86.5
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 02

The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective				57	58
Annual Indicator				57.0	57.0
Numerator				142,384	142,384
Denominator				249,840	249,840
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	58	58	58	58	58
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective				58.3	59.3
Annual Indicator				58.3	58.3
Numerator				399,631	399,631
Denominator				685,206	685,206
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	59.3	59.3	59.3	59.3	59.3
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

PERFORMANCE MEASURE # 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective				52.9	52.9
Annual Indicator				52.9	52.9
Numerator				366,173	366,173
Denominator				692,198	692,198
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	52.9	52.9	52.9	52.9	52.9
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

PERFORMANCE MEASURE # 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective				76.8	78
Annual Indicator				76.8	76.8
Numerator				193,680	193,680
Denominator				252,253	252,253
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	78	78	78	78	78
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

PERFORMANCE MEASURE # 06

The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective					
Annual Indicator					5.8
Numerator					
Denominator					
Is the Data Provisional or Final?					Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

PERFORMANCE MEASURE # 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	75	76	77	78	80
Annual Indicator	74.3	72.4	68.5	73.7	71.6
Numerator	373,608	371,036	331,520	362,212	362,246
Denominator	502,837	512,481	483,972	491,468	505,925
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	80	80	80	80	80
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

PERFORMANCE MEASURE # 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	50	50	50	50	50
Annual Indicator	47.1	46.1	41.6	38.9	42.0
Numerator	20,597	20,112	19,631	18,683	20,195
Denominator	437,509	435,888	472,252	480,073	481,349
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	50	50	50	50	50
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

PERFORMANCE MEASURE # 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	17	17	18	19	20
Annual Indicator	16.9	19.7	21.6	21.7	37.5
Numerator	544	642	610	596	2,687
Denominator	3,211	3,253	2,828	2,749	7,156
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	21	22	23	23	23
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5
Annual Indicator	5.7	6.1	5.8	5.3	5.6
Numerator	255	265	264	247	262
Denominator	4,458,673	4,351,696	4,579,234	4,628,121	4,647,317
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 11

Percentage of mothers who breastfeed their infants at hospital discharge.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	65	70	75	80	80
Annual Indicator	63.1	66.5	67.8	69.4	72.2
Numerator	218,392	234,718	249,517	256,959	268,013
Denominator	346,216	352,960	368,019	370,258	371,429
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	80	80	80	80	80
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	24	30	10	46	92
Annual Indicator	12.1	12.8	12.2	30.8	84.3
Numerator	41,937	45,000	45,000	113,972	313,116
Denominator	346,216	350,418	368,019	370,258	371,429
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	92	92	92	92	92
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	24	21	23	23	22
Annual Indicator	25.4	24.3	23.0	21.3	23.0
Numerator	1,445,824	1,400,315	1,353,955	1,271,265	1,376,890
Denominator	5,692,222	5,762,614	5,886,759	5,968,378	5,986,708
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	20	20	20	20	20
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 14

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	47	48	50	52	52
Annual Indicator	47.0	44.6	41.7	37.7	43.7
Numerator	722,972	678,434	656,760	624,214	726,473
Denominator	1,537,180	1,521,177	1,573,135	1,655,442	1,661,900
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	53	53	54	54	54
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 15

The percent of very low birth weight infants among all live births.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	1	1.2	1.2	1.1	1.1
Annual Indicator	1.3	1.3	1.3	1.3	1.3
Numerator	4,521	4,526	4,605	4,808	4,867
Denominator	342,199	349,157	363,325	365,092	364,858
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	1	1	1	1	1
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	11.5	11	11	10.5	10.5
Annual Indicator	9.5	7.7	9.4	7.6	8.2
Numerator	147	120	154	127	136
Denominator	1,550,680	1,563,212	1,636,232	1,663,111	1,653,654
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	10	10	10	10	10
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	55	55	55	55	55
Annual Indicator	52.9	49.9	52.2	52.6	52.1
Numerator	2,392	2,259	2,402	2,530	2,552
Denominator	4,521	4,526	4,605	4,808	4,894
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	55	55	55	55	55
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

PERFORMANCE MEASURE # 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	81	83	85	85	85
Annual Indicator	77.8	77.7	76.2	77.7	80.2
Numerator	266,152	271,133	276,720	283,822	292,718
Denominator	342,199	349,157	363,325	365,092	364,858
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	85	85	85
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE PERFORMANCE MEASURE # 1

Change in institutionalized CSHCN, as percent of previous year.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective		100	100	95	90
Annual Indicator		97.8	99.4	96.2	101.8
Numerator		1,260	1,253	1,206	1,228
Denominator		1,288	1,260	1,253	1,206
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

STATE PERFORMANCE MEASURE # 2

Percent of children and adolescents (aged 13-19) who choose healthy behaviors

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	67	68	69	70	71
Annual Indicator	67.4	68.3	69.1	62.5	66.8
Numerator	1,445,290	1,478,068	1,577,994	1,451,817	1,544,853
Denominator	2,145,015	2,165,211	2,283,133	2,321,233	2,313,512
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	72	73	74	74	74
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

STATE PERFORMANCE MEASURE # 3

Percent of infants and children (aged 0-12) who thrive

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	65	70	72	74	76
Annual Indicator	68.7	66.0	64.2	62.2	66.1
Numerator	2,888,771	2,816,003	2,738,647	2,688,777	2,869,042
Denominator	4,202,338	4,269,315	4,263,103	4,321,660	4,339,841
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	78	80	80	80	80
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE PERFORMANCE MEASURE # 4

Ratio of Black low birth weight (LBW) rate to White LBW rate

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective				1.6	1.6
Annual Indicator	1.9	1.9	2.0	1.9	1.8
Numerator	12.6	12.6	12.7	12.9	12.4
Denominator	6.7	6.7	6.5	6.9	6.9
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE PERFORMANCE MEASURE # 5

The Prevalence of Childhood Obesity

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective		20	20	19	17
Annual Indicator	20.3	21.1	21.9	23.2	24.1
Numerator	75,499	80,868	86,533	92,979	100,071
Denominator	371,256	383,480	396,021	400,238	416,010
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	16	15	15	15	15
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE PERFORMANCE MEASURE # 6

Incidence of carious lesions among 3rd to 7th grade children.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	45	43	43	43	43
Annual Indicator	46.8	54.7	49.9	48.7	43.2
Numerator	3,407	3,829	3,289	2,819	8,092
Denominator	7,276	7,001	6,596	5,784	18,735
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	43	43	43	43	43
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE PERFORMANCE MEASURE # 7

Percent of female clients suspected of being victims of relationship abuse.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	4	3.9	3.9	3.8	3.8
Annual Indicator	3.9	3.9	4.0	3.9	3.9
Numerator	13,464	19,539	18,271	19,148	19,148
Denominator	347,884	505,910	457,638	495,329	495,329
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	3.7	3.7	3.6		
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE PERFORMANCE MEASURE # 8

Percentage of Texas population with fluoridated water.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	70	71	72	73	74
Annual Indicator	70.0	70.3	68.4	68.5	68.9
Numerator	13,831,730	14,053,610	14,265,570	14,612,430	14,807,260
Denominator	19,759,610	19,995,430	20,851,820	21,325,020	21,501,000
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	75	75	75	75	75
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

FORM NOTES FOR FORM 11

None

FIELD LEVEL NOTES

1. **Section Number:** Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Unduplicated screening data are not available for 2002 for all conditions mandated by the State-sponsored Newborn Screening Program. Therefore, this measure cannot be completed as defined for this submission.

2. **Section Number:** Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The 2002 indicator is based on the State estimates from SLAITS. A conservative 1% increase forms the basis of established targets from 2003 to 2007.

3. **Section Number:** Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The 2002 indicator is based on the State estimates from SLAITS. A conservative 1% increase forms the basis of established targets from 2003 to 2007.

4. **Section Number:** Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The 2002 indicator is based on the State estimates from SLAITS. This measure was held constant from 2002 to 2007.

5. **Section Number:** Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   The 2002 indicator is based on the State estimates from SLAITS. A conservative 1% increase forms the basis of established targets from 2003 to 2007.

6. **Section Number:** Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[SECS 505 (A)(2)(B)(III) AND 506 (A)(2)(A)(III)]
STATE: TX

OUTCOME MEASURE # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	5.9	5.7	5.5	5.5	5.5
Annual Indicator	6.4	6.2	5.7	6.0	5.5
Numerator	2,180	2,160	2,064	2,181	2,018
Denominator	342,199	349,157	363,325	365,092	364,858
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

OUTCOME MEASURE # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	1.8	1.8	1.7	1.7	1.7
Annual Indicator	2.2	2.5	2.4	2.3	2.3
Numerator	11.6	12.5	11.4	12	10.7
Denominator	5.2	5.1	4.8	5.2	4.6
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

OUTCOME MEASURE # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5
Annual Indicator	4.0	3.9	3.4	3.7	3.4
Numerator	1,361	1,362	1,226	1,356	1,249
Denominator	342,199	349,157	363,325	365,092	364,858
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

OUTCOME MEASURE # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5
Annual Indicator	2.4	2.3	2.3	2.3	2.1
Numerator	819	798	838	825	769
Denominator	342,199	349,157	363,325	365,092	364,858
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	2.4	2.4	2.4	2.4	2.4
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

OUTCOME MEASURE # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	9	9	9	9	9
Annual Indicator	9.8	9.8	8.9	9.7	9.0
Numerator	3,360	3,445	3,263	3,548	3,315
Denominator	342,199	351,240	365,362	367,284	366,524
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	9	8.9	8.9	8.9	8.9
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

OUTCOME MEASURE # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective	25.8	24.9	24	23.1	23.1
Annual Indicator	24.1	25.4	24.2	24.6	23.2
Numerator	1,073	1,146	1,106	1,140	1,080
Denominator	4,458,673	4,518,368	4,579,234	4,628,121	4,647,317
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	23.1	23.1	23.1	23.1	23.1
Annual Indicator					
Numerator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Denominator					

STATE OUTCOME MEASURE # 7

The ratio of the black perinatal mortality rate to the white perinatal mortality rate.

Annual Objective and Performance Data

	1998	1999	2000	2001	2002
Annual Performance Objective			1	1	1
Annual Indicator	0.6	0.5	0.5	0.5	0.5
Numerator	10	9	8	9	9
Denominator	16	17	16	17	17
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2003	2004	2005	2006	2007
Annual Performance Objective	1	1	1	1	1
Annual Indicator					
Numerator					
Denominator					

Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.

FORM NOTES FOR FORM 12

None

FIELD LEVEL NOTES

None

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS
STATE: TX

General Instructions/Notes:
Referring to the rating key below, select the appropriate rating for your state (0-3) in response to each of the questions (1-6). For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

3

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

1

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

1

4. Family members are involved in service training of CSHCN staff and providers.

1

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

0

6. Family members of diverse cultures are involved in all of the above activities.

1

Total Score: 7

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

FORM NOTES FOR FORM 13

None

FIELD LEVEL NOTES

None

FORM 14
LIST OF MCH PRIORITY NEEDS

[Sec. 505(a)(5)]

STATE: TX FY: 2004

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. To reduce the number of CSHCN in nursing facilities and other congregate care settings.
2. To increase the number of children and adolescents who make healthy lifestyle choices for themselves.
3. To increase the number of children and adolescents who thrive.
4. To reduce disparity in low birth weight rates between Black and White infants.
5. To decrease child and adolescent obesity rates.
6. To determine Texas baseline children's dental health status.
7. To decrease the prevalence of relationship violence.
8.
9.
10.

FORM NOTES FOR FORM 14

None

FIELD LEVEL NOTES

None

FORM 15
TECHNICAL ASSISTANCE(TA) REQUEST

General Instructions/Notes:
This form contains a preliminary statement of the technical assistance that your State anticipates for the application year. This is a "snap shot" of your technical assistance needs at the time of your application. To formally request technical assistance during the year, contact the Maternal and Child Health Bureau directly to submit a specific request. For more detailed instructions on this form, click on the question mark icon in the upper-right corner of the form.

STATE: TX **APPLICATION YEAR: 2004**

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**National Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 15	Low-cost strategies/best practices that can be implemented at the state and local level to reduce low birth weight and very low birth weight births.	Identification of low-cost strategies/best practices that have proved effective in other states and that can be adapted for use in Texas communities would be helpful.	Not Known
2.	**National Performance Measure Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: 18	Low-cost strategies/best practices that can be implemented at the state and local level to promote early entry into prenatal care.	Identification of low-cost,effective strategies that have proved effective in other states and that can be adapted for use in Texas communities would be helpful.	Not Known
3.	**Data-related Issues - Performance Indicators** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:	Comprehensive assessment of how women of childbearing age in Texas are doing on national health indicators	For use by state and local health stakeholders in strategic planning and to establish the link between data and outcomes	Not Known
4.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Training Team from Social Marketing in Public Health Conference travel to Texas to train large group of TDH employees and stakeholders in social marketing.	To provide low cost, effective way for TDH employees and stakeholders to receive nationally renowned training.	University of South Florida
5.	**Other** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	Low-cost strategies/best practices regarding CSHCN management and expenditure projections.	Identification of low cost strategies in managing CSCHCN due to changing Medicaid and CHIP state requirements and assistance in projecting expenditures	Not known

FORM 15 (continued)

6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
9.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: _____			

FORM NOTES FOR FORM 15

None

FIELD LEVEL NOTES

None

FORM 16
STATE PERFORMANCE AND OUTCOME MEASURE DETAIL SHEET
STATE: TX

SP # 1

PERFORMANCE MEASURE: Change in institutionalized CSHCN, as percent of previous year.

STATUS: Active

GOAL Promote the health of children with special health care needs and prevent secondary conditions.

DEFINITION

Numerator:
Number of CSHCH institutionalized in current year

Denominator:
Number of CSHCN institutionalized in previous year

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES State CSHCN program.

SIGNIFICANCE Many children with activity limitations or cognitive impairments need ongoing and long-term assistance, yet some do not require institutional care. In 1998, there were 1,288 Medicaid-eligible CSHCN who were institutionalized in state schools, ICF/MR, and nursing homes. Every CSH belongs in a family with a consistent caregiver who takes responsibility for the child's growth, development, and overall well-being. CSHCN still reside in nursing facilities and other congregate care settings. Families with CSHCN need family support services and care options so that CSHCN can remain in families within the community.

SP # 2

PERFORMANCE MEASURE: Percent of children and adolescents (aged 13-19) who choose healthy behaviors

STATUS: Active

GOAL Improve the health and well-being of children, adolescents, and families.

DEFINITION

Numerator:
Number of adolescents who choose healthy behaviors. (numerator: Weighted index of 9 measures: alcohol use, tobacco use, teen pregnancy, STD, motor vehicle deaths, homicide, suicide, school dropout, and Medicaid checkups, where negative measures are inverted to positive.)

Denominator:
Total state population aged 13-19 years.

Units: 100 **Text:** percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES State Drug Use survey, Bureau of Vital Statistics, Texas Educational Agency, National Heritage Insurance Company.

SIGNIFICANCE Social changes of the last 40 years have led to dramatic shift in family, neighborhood and community patterns of interaction. Children are left to their own devices while parents are at the workplace, neighbors are absent, and elder citizens are in residential facilities. Recent evidence shows that, more than any other factor, health decisions among adolescents are influenced by the degree of connectedness they feel to family, school, and community. If we are to influence positively the health decisions that our children and youth make, we have to go beyond providing information and teaching skills. We have to ensure that our youth experience a strong sense of connection and caring by the adults directly involved in their lives. We must realign our public health practice to consider and support the quality of life of our children and youth. In other words, the Texas Title V future initiative is to create a critical mass of asset-building energy around all children and adolescents, to the point that asset-building is a way of life in families, neighborhoods, and schools.

FORM 16 (continued)

SP # 3

PERFORMANCE MEASURE: Percent of infants and children (aged 0-12) who thrive

STATUS: Active

GOAL Improve the health and well-being of children, adolescents, and families.

DEFINITION

Numerator:
Number of children and adolescents who thrive. (Numerator: weighted index of 6 measures: child-abuse, unintentional injuries, death rate, Medicaid checkups, immunizations, and elevated blood lead levels, where negative measures are inverted to positive.)

Denominator:
Total state population aged 0-12 years.

Units: 100 **Text:** percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES State Child Protective Services, Bureau of Vital Statistics, National Heritage Insurance Company, Center for Disease control for state immunization estimates, State Lead Statistics Program.

SIGNIFICANCE Social changes of the last 40 years have led to a dramatic shift in family, neighborhood and community patterns of interaction. Children are left to their own devices while parents are at the workplace, neighbors are absent, and elder citizens are in residential facilities. Recent evidence shows that, more than any other factor, health decisions among adolescents are influenced by the degree of connectedness they feel to family, school, and community. If we are to influence positively the health decisions that our children and youth make, we have to go beyond providing information and teaching skills. We have to ensure that our youth experience a strong sense of connection and caring by the adults directly involved in their lives. We must realign our public health practice to consider and support the quality of life of our children and youth. In other words, the Texas Title V future initiative is to create a critical mass of asset-building energy around all children and adolescents, to the point that asset-building is a way of life in families, neighborhoods, and schools.

SP # 4

PERFORMANCE MEASURE: Ratio of Black low birth weight (LBW) rate to White LBW rate

STATUS: Active

GOAL Reduce health disparities in birth outcomes.

DEFINITION

Numerator:
Number of African-American live births with a birth weight less than 2500 grams in the calender year.

Denominator:
Number of White live births with a birth weight less than 2500 grams in the calender year.

Units: 1 **Text:** Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES Birth certificates are the source for LBW.

SIGNIFICANCE LBW is the risk factor most closely associated with neonatal death; thus, improvements in infant birth weight can contribute substantially to reductions in the infant mortality rate. Of all infants born at low birth weight, the smallest (those weighing less than 1,500 grams) are at highest risk of dying in their first year. Texas' births will exceed 400,000 within three years. Texas must be able to assure adequate resources and planning for the growing number of births throughout the state. Low birth weight and other perinatal health indicators are stabilizing or decreasing statewide in Texas, however, LBW is not decreasing among African American families. A failure to address the large number of LBW births will mean Texas will continue to need to maintain resources to support a growing number of high-risk low birth weight births throughout the state. Birth data in Texas clearly shows that specific populations are most affected by LBW, primarily African American families. Relative to the white population, LBW is up to twice as common for African American families. Smoking accounts for 20 to 30 percent of all LBW births in the United States. The effect of smoking on LBW rates appears to be attributable to intrauterine growth retardation rather than to preterm delivery. VLBW is primarily associated with preterm bi[illegible] which may be associated with the use of illicit drugs during pregnancy.

FORM 16 (continued)

SP # 5

PERFORMANCE MEASURE: The Prevalence of Childhood Obesity

STATUS: Active

GOAL To assure conditions in communities and schools which promote health eating and physical activity patterns in children and adolescents.

DEFINITION

Numerator:
Number of obese children age 0-5 in Texas (>95 percentile BMI)

Denominator:
Number of children age 0-5 in Texas

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES State WIC data.

SIGNIFICANCE Childhood obesity is associated with adverse medical and psycho-social consequences. Overweight acquired during childhood or adolescence may persist into adulthood with increased risks of some chronic disease later in life. As a result, the rising prevalence of obesity and chronic disease will place more burdens on the health care system, including increased costs of medical care. Following the published data from the CDC's Third National Health and Nutrition Examination Survey (NHANES III), concern has been expressed that the prevalence of obesity in children and adolescents may be increasing in Texas, but definitive data are lacking. Therefore, Title V leadership are commited to establishing a baseline to assess the extent of obesity in childhood in Texas and, accordinly, develop a

SP # 6

PERFORMANCE MEASURE: Incidence of carious lesions among 3rd to 7th grade children.

STATUS: Active

GOAL Establish an oral health data resource center.

DEFINITION

Numerator:
Number of 3rd - 7th grade children with carious lesions.

Denominator:
Number of 3rd - 7th grade children.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES Numerator: State oral health status datafiles are source of data for children with cariuos lesions. Denominator: Population numbers are available from the census; school enrollment from Texas Education Agency.

SIGNIFICANCE It is imperative for the Title V Oral Health Program to determine baseline children's dental health status. This baseline will allow dental staff to assess unmet needs that should be addressed, set realistic targets, and develop targeted dental caries prevention activities in order to reduce the prevalence of dental caries.

FORM 16 (continued)

SP # 7

PERFORMANCE MEASURE: Percent of female clients suspected of being victims of relationship abuse.

STATUS: Active

GOAL Increase detection of and appropriate responses to women and adolescents seeking health services who are suspected victims of relationship abuse.

DEFINITION

Numerator:
Number of female clients suspected of being victims of relationship abuse.

Denominator:
Number of female clinets receiving services from Title V, X, and XX clinics.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES Numerator: Dept. of Public Safety Records. Denominator: Title V, X, and XX contractor reports.

SIGNIFICANCE Relationship violence often results in emergency room visits, physician office visits, hospitalization, lost days of work, mental or emotional problems, or death. Studies show that more than half of the women murdered in the United States are killed by their male partners. It is estimated that, nationally, domestic violence leads to $44 million in total annual medical costs and 175,000 lost days of work. Texas contributes to these alarming statistics. Results from the five-year Title X Service Enhancement Project (see needs assessment section...) indicate that Texas women receiving services from four TDH family planning contractors said they had experienced some form of sexual assault (27.3%) and physical abuse (38%). Consequently, TDH Women's Health Division staff have conducted a series of activities for Title X family planning providers to prevent abuse and identify victims for referral. In FY 99, similar activities are planned to be expanded to Title V and other interested health care providers.

SP # 8

PERFORMANCE MEASURE: Percentage of Texas population with fluoridated water.

STATUS: Active

GOAL Prevent and control oral diseases and improve access to related services.

DEFINITION

Numerator:
Population with fluoridated water statewide.

Denominator:
Total state population

Units: 100 **Text:** percent

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES State Dental Fluoridation Program; State Data Center, Texas A&M University Population Estimates.

SIGNIFICANCE Community water fluoridation has been the primary basis for the prevention of dental decay, which has been shown to lower the need for dental care. In 1999, 70% of the total Texas population had access to fluoridated water. Title V Oral Health Division staff will continue to maintain current water plant systems and to increase the proportion of the Texas population served by community water systems with optimally fluoridated water. This is a win-win proposition for the Title V program: community water fluoridation is equitable since the entire population benefits regardless of financial resources, and it reduces or eliminates disparaities in preventing dental caries among different socioeconomic, racial and ethnic groups.

FORM 16 (continued)

SO # 7

OUTCOME MEASURE: The ratio of the black perinatal mortality rate to the white perinatal mortality rate.

STATUS: Active

GOAL To reduce the disparity (ratio) between the Black and White perinatal mortality.

DEFINITION

Numerator:
The Black perinatal mortality rate per 1,000 live births.

Denominator:
The White perinatal mortality rate per 1,000 live births.

Units: 1 **Text:** Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

DATA SOURCES AND DATA ISSUES Vital records collected by the State.

SIGNIFICANCE Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care. Overall, there were 3,445 or 9.8 per 1,000 live births perinatal deaths in 1999. These deaths revealed a significant racial disparity. The disparity rate for Black perinatal mortality rate (11 per 1,000 live births) is almost twice the White rate of 6 per 1,000 live births. Black women are twice as likely as White women to experience low birth weight, neonatal and fetal deaths.

FORM NOTES FOR FORM 16

None

FIELD LEVEL NOTES

None

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07 & 08 - MULTI-YEAR DATA
STATE: TX

HEALTH SYSTEMS CAPACITY MEASURE # 01

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	32.2	32.2	38.3	39.0	39.5
Numerator	2,172	2,172	12,436	12,891	19,885
Denominator	673,922	673,922	3,249,256	3,301,528	5,035,841
Is the Data Provisional or Final?				Final	Provisional

HEALTH SYSTEMS CAPACITY MEASURE # 02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	83.6	79.3	75.0	69.2	70.6
Numerator	151,680	145,074	145,982	140,257	158,431
Denominator	181,441	182,971	194,540	202,576	224,388
Is the Data Provisional or Final?				Final	Provisional

HEALTH SYSTEMS CAPACITY MEASURE # 03

The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	0	0	3.0	3.0	2.0
Numerator			6,921	15,035	14,549
Denominator			230,682	501,167	727,452
Is the Data Provisional or Final?				Final	Provisional

HEALTH SYSTEMS CAPACITY MEASURE # 04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	53.4	67.0	65.2	66.9	66.9
Numerator	181,854	232,877	236,817	243,177	243,177
Denominator	340,778	347,707	363,325	363,673	363,673
Is the Data Provisional or Final?				Final	Provisional

HEALTH SYSTEMS CAPACITY MEASURE # 07

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	49.9	48.2	53.0	51.2	51.4
Numerator	364,495	340,032	175,943	172,102	194,057
Denominator	730,932	705,300	332,021	335,966	377,746
Is the Data Provisional or Final?				Final	Provisional

HEALTH SYSTEMS CAPACITY MEASURE # 08

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	61.3	50.5	52.2	50.8	68.5
Numerator	30,674	23,889	24,831	25,546	31,289
Denominator	50,076	47,350	47,550	50,322	45,689
Is the Data Provisional or Final?				Final	Final

FORM NOTES FOR FORM 17

None

FIELD LEVEL NOTES

1. **Section Number:** Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   2000 was derived from the 2000 CHIP Enrollments and Eligibility by County Report: 3% of the total State enrollment (230,682*.03) for infants <1 year.

   Reference for 2001 & 2002: Children's Health Insurance Program in Texas: The New Enrollee Survey Report 2003. March 2003

2. **Section Number:** Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2004
   Field Note:
   Source:
   TDH, Bureau of Children's Health, Output Case Managemnt Report, SSI dual eligibles estimated as 40% of joint SSI/CSHCN caseload (2001) and 10% of contractor caseload; SSA, Persons Receiving Federally Administered Payments by State and Age.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #05
(MEDICAID AND NON-MEDICAID COMPARISON)
STATE: TX

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
a) *Percent of low birth weight (< 2,500 grams)*	2001	Payment source from birth certificate	8.2	7.3	7.6
b) *Infant deaths per 1,000 live births*	2001	Payment source from birth certificate	5.7	6.1	6
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2001	Payment source from birth certificate	72.4	80.2	77.7
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2001	Payment source from birth certificate	65.7	67.4	66.9

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(MEDICAID ELIGIBILITY LEVEL)
STATE: TX

INDICATOR #06 ***The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL** **MEDICAID** **(Valid range: 100-300 percent)**
a) *Infants (0 to 1)*	2002	185
b) *Medicaid Children* (Age range 1 to 5) (Age range 6 to 18) (Age range 19 to 20)	2002	 133 100 100
c) *Pregnant Women*	2002	185

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR #06(SCHIP ELIGIBILITY LEVEL)
STATE: TX

INDICATOR #06 ***The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.***	**YEAR**	**PERCENT OF POVERTY LEVEL** **SCHIP**
a) *Infants (0 to 1)*	2000	200
b) *Medicaid Children* (Age range 1 to 19) (Age range _____ to _____) (Age range _____ to _____)	2000	200
c) *Pregnant Women*		

FORM NOTES FOR FORM 18

None

FIELD LEVEL NOTES

1. **Section Number:** Indicator 06 - Medicaid
   Field Name: Med_Children
   Row Name: Medicaid Children
   Column Name:
   Year: 2004
   Field Note:
   Percent of poverty level for Medicaid aged range 19 to 20 should be 17%. Data system would not allow less than 100% to be entered.

2. **Section Number:** Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2004
   Field Note:
   Not Applicable

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TX

General Instruction:
The purpose of this form is to show the State MCH data capacity and whether the MCH program has the ability to obtain timely analyses of certain data for programmatic and policy issues.

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Informatioin)

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) *	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES **Annual linkage of infant birth and infant death certificates**	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS **Hospital discharge survey for at least 90% of in-State discharges**	1	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR - REPORTING AND TRACKING FORM
STATE: TX

HEALTH SYSTEMS CAPACITY INDICATOR #09B (Data Capacity - Adolescent Tobacco Use)
(The Percent of Adolescents in Grade 9 through 12 who Reported Using Tobacco Products in the Past Month)

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
Other: 2002 Texas School Survey, Texas Commission on Alco	3	No

HEALTH SYSTEMS CAPACITY INDICATOR #09C (Data Capacity) Overweight/Obesity
(The Ability of the State to Determine the Percent of Children Who are Obese or Overweight)

Data Source	Does your state participate in this survey/data source? (Select 1 - 3)*	Does your MCH program have direct access to this electronic database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
Pediatric Nutrition Surveillance System (PedNSS)	3	Yes
WIC Program Data	3	Yes
Other:		

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

FORM NOTES FOR FORM 19

None

FIELD LEVEL NOTES

None

FORM 20
HEALTH STATUS INDICATORS #01-#05
MULTI-YEAR DATA
STATE: TX

HEALTH STATUS INDICATOR MEASURE # 01A

The percent of live births weighing less than 2,500 grams.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	7.4	7.4	7.4	7.6	7.5
Numerator	25,400	25,702	26,751	27,585	28,258
Denominator	342,199	349,157	363,325	365,092	374,521
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 01B

The percent of live singleton births weighing less than 2,500 grams.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	6.0	6.0	5.9	6.1	6.1
Numerator	20,060	20,343	21,319	21,590	22,028
Denominator	333,196	339,894	359,079	354,967	363,737
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 02A

The percent of live births weighing less than 1,500 grams.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	1.3	1.3	1.3	1.3	1.3
Numerator	4,521	4,526	4,605	4,808	4,898
Denominator	342,199	349,157	363,325	365,992	374,479
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 02B

The percent of live singleton births weighing less than 1,500 grams.

	Annual Indicator Data				
	1998	**1999**	**2000**	**2001**	**2002**
Annual Indicator	1.0	1.0	1.0	1.0	1.0
Numerator	3,434	3,486	3,521	3,668	3,731
Denominator	333,196	339,894	353,501	354,967	363,737
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	11.4	11.9	11.4	10.9	10.8
Numerator	548	557	560	541	541
Denominator	4,796,673	4,678,839	4,910,004	4,979,782	4,999,699
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 03B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	5.6	6.4	5.5	5.4	5.3
Numerator	271	298	268	268	263
Denominator	4,796,673	4,678,839	4,910,004	4,979,782	4,999,699
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 03C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	29.6	31.8	32.4	31.1	30.7
Numerator	913	938	1,010	1,014	1,004
Denominator	3,085,820	2,952,100	3,116,579	3,259,422	3,272,868
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 04A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	53.6	58.3	85.0	115.3	105.2
Numerator	2,571	2,729	4,174	5,742	5,261
Denominator	4,796,673	4,678,839	4,910,004	4,979,782	4,999,699
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 04B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	19.9	23.4	27.7	37.2	41.1
Numerator	953	1,094	1,359	1,851	2,054
Denominator	4,796,673	4,678,839	4,910,004	4,979,782	4,999,699
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 04C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	74.4	87.7	109.8	143.7	160.3
Numerator	2,296	2,590	3,423	4,684	5,247
Denominator	3,085,820	2,952,100	3,116,579	3,259,422	3,272,868
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 05A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	28.4	29.3	29.8	29.0	28.5
Numerator	21,469	21,863	23,490	23,250	22,835
Denominator	755,127	746,797	788,770	802,145	801,380
Is the Data Provisional or Final?				Final	Provisional

HEALTH STATUS INDICATOR MEASURE # 05B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

	Annual Indicator Data				
	1998	1999	2000	2001	2002
Annual Indicator	7.0	7.2	7.8	8.0	8.2
Numerator	26,126	27,762	30,763	32,298	32,949
Denominator	3,743,036	3,840,769	3,951,306	4,020,832	4,009,566
Is the Data Provisional or Final?				Final	Provisional

FORM NOTES FOR FORM 20

None

FIELD LEVEL NOTES

None

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2001 Is this data from a State Projection? No

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	316,646	259,546	45,637	1,349	10,114	0	0	0
Children 1 through 4	1,241,790	1,020,513	176,747	5,278	39,252	0	0	0
Children 5 through 9	1,618,001	1,344,353	215,779	6,521	51,348	0	0	0
Children 10 through 14	1,613,683	1,321,566	234,475	8,793	48,849	0	0	0
Children 15 through 19	1,628,249	1,337,011	233,588	9,227	48,423	0	0	0
Children 20 through 24	1,524,623	1,254,976	215,178	8,607	45,862	0	0	0
Children 0 through 24	7,942,992	6,537,965	1,121,404	39,775	243,848	0	0	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	184,911	131,735	0
Children 1 through 4	738,032	503,758	0
Children 5 through 9	992,615	630,593	0
Children 10 through 14	1,039,223	574,460	0
Children 15 through 19	1,069,398	558,851	0
Children 20 through 24	1,004,260	520,363	0
Children 0 through 24	5,028,439	2,919,760	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2001 Is this data from a State Projection? No

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	1,072	822	240	2	3	0	1	4
Women 15 through 17	18,701	15,640	2,864	38	90	2	18	49
Women 18 through 19	34,076	28,713	4,930	83	227	7	28	88
Women 20 through 34	273,603	233,090	29,165	635	9,348	68	317	980
Women 35 or older	38,050	32,374	3,403	81	1,991	10	46	145
Women of all ages	365,502	310,639	40,602	839	11,659	87	410	1,266

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	366	702	2
Women 15 through 17	6,905	11,684	60
Women 18 through 19	15,060	18,765	132
Women 20 through 34	144,525	127,191	923
Women 35 or older	24,093	13,685	123
Women of all ages	190,949	172,027	1,240

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2001 Is this data from a State Projection? No

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	2,183	1,644	489	1	42	0	2	5
Children 1 through 4	533	431	92	1	8	0	0	1
Children 5 through 9	269	220	41	1	7	0	0	0
Children 10 through 14	339	264	67	1	6	0	0	1
Children 15 through 19	1,160	964	166	1	29	0	0	0
Children 20 through 24	1,518	1,223	269	4	22	0	0	0
Children 0 through 24	6,002	4,746	1,124	9	114	0	2	7

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1,231	944	
Children 1 through 4	302	229	
Children 5 through 9	161	107	
Children 10 through 14	215	122	
Children 15 through 19	729	425	
Children 20 through 24	949	564	
Children 0 through 24	3,587	2,391	0

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	3,901,190	2,843,015	853,487	0	0	0	0	204,688	2001
Percent in household headed by single parent	27								2001
Percent in TANF (Grant) families	4.3								2001
Number enrolled in Medicaid	887,572	436,470	405,521	0	0	0	0	45,581	2002
Number enrolled in SCHIP	378,275	269,157	94,569	0	7,274	0	0	7,275	2002
Number living in foster home care	7,574	3,600	3,579	43	25	0	0	327	2002
Number enrolled in food stamp program	60,761	30,314	29,595	166	686	0	0	0	2002
Number enrolled in WIC	365,649	203,313	146,994	1,128	14,214	0	0	0	2002
Rate (per 100,000) of juvenile crime arrests	1.8	0.7	0.4	0	0	0	0	0	
Percentage of high school drop-outs (grade 9 through 12)	1.4	0.8	1.8	1.2	0.7	0	0	0	2001

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	3,901,190	2,698,178		2001
Percent in household headed by single parent				
Percent in TANF (Grant) families				
Number enrolled in Medicaid	887,572	1,172,852		2002
Number enrolled in SCHIP	378,275	349,177		2002
Number living in foster home care	7,574	3,248		2002
Number enrolled in food stamp program	60,761	144,607		2002
Number enrolled in WIC	365,649	724,985		2002
Rate (per 100,000) of juvenile crime arrests	1.1	0.8		2002
Percentage of high school drop-outs (grade 9 through 12)	1	2		2001

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2000 Is this data from a State Projection? No

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	5,607,222
Living in urban areas	5,401,060
Living in rural areas	1,145,176
Living in frontier areas	64,018
Total - all children 0 through 19	6,610,254

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2001 Is this data from a State Projection? Yes

POVERTY LEVELS	TOTAL
Total Population	21,325,018
Percent Below: 50% of poverty	8.1
100% of poverty	14.9
200% of poverty	36.4

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA
STATE: TX

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2001 Is this data from a State Projection? Yes

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	6,642,893
Percent Below: 50% of poverty	12.1
100% of poverty	24.2
200% of poverty	48.2

FORM NOTES FOR FORM 21

None

FIELD LEVEL NOTES

1. **Section Number:** Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2004
   Field Note:
   Agreement Between Tables stated below is NOT working:

   For each row in 06B, the sum of the three columns (Total NOT Hispanic or Latino, Total Hispanic or Latino, and Ethnicity Not Reported) must equal the figure in the corresponding row and column, "Total All Races" in 06A.

   Total for all children 0 through 19 for total NOT Hispanic or Latino =3,901,190
   Total for all children 0 through 19 for total Hispanic or Latino
   = 2,698,178

   Total for all children 0 through 19 for all races = 6,599,368

2. **Section Number:** Indicator 09A
   Field Name: HSIRace_MedicaidNo
   Row Name: Number enrolled in Medicaid
   Column Name:
   Year: 2004
   Field Note:
   Agreement Between Tables stated below is NOT working:

   For each row in 06B, the sum of the three columns (Total NOT Hispanic or Latino, Total Hispanic or Latino, and Ethnicity Not Reported) must equal the figure in the corresponding row and column, "Total All Races" in 06A.

   Race/Ethnicity distribution is based on Medicaid Race/Ethnicity distribution for the 1999 Medicaid Race/Ethnicity THSteps eligible population age 0-20.

3. **Section Number:** Indicator 09A
   Field Name: HSIRace_SCHIPNo
   Row Name: Number enrolled in SCHIP
   Column Name:
   Year: 2004
   Field Note:
   Agreement Between Tables stated below is NOT working:
   For each row in 06B, the sum of the three columns (Total NOT Hispanic or Latino, Total Hispanic or Latino, and Ethnicity Not Reported) must equal the figure in the corresponding row and column, "Total All Races" in 06A.

4. **Section Number:** Indicator 09A
   Field Name: HSIRace_FoodStampNo
   Row Name: Number enrolled in food stamp program
   Column Name:
   Year: 2004
   Field Note:
   Agreement Between Tables stated below is NOT working:
   For each row in 06B, the sum of the three columns (Total NOT Hispanic or Latino, Total Hispanic or Latino, and Ethnicity Not Reported) must equal the figure in the corresponding row and column, "Total All Races" in 06A.

5. **Section Number:** Indicator 09A
   Field Name: HSIRace_WICNo

Form Notes For Form 21 (continued)

Row Name: Number enrolled in WIC
Column Name:
Year: 2004
Field Note:
Agreement Between Tables stated below is NOT working:
For each row in 06B, the sum of the three columns (Total NOT Hispanic or Latino, Total Hispanic or Latino, and Ethnicity Not Reported) must equal the figure in the corresponding row and column, "Total All Races" in 06A.

6. **Section Number:** Indicator 09B
Field Name: HSIEthnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2004
Field Note:
Race /ethnicity distribution is based on 1999 Medicaid Race ethnicity estimates for the THSteps Eligible population Age 0 -20.

7. **Section Number:** Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2004
Field Note:
Agreement Between Tables stated below is NOT working:
For each row in 06B, the sum of the three columns (Total NOT Hispanic or Latino, Total Hispanic or Latino, and Ethnicity Not Reported) must equal the figure in the corresponding row and column, "Total All Races" in 06A.